eHealth, Inc.
Form 10-Q
August 07, 2013

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

FORM 10-Q

þ QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the quarterly period ended June 30, 2013

OR

¨ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from to

001-33071

(Commission File Number)

EHEALTH, INC.

(Exact name of registrant as specified in its charter)

Delaware	56-2357876
(State or other jurisdiction of incorporation or organization)	(I.R.S Employer Identification No)

440 EAST MIDDLEFIELD ROAD

MOUNTAIN VIEW, CALIFORNIA 94043

(Address of principal executive offices)

(650) 584-2700

(Registrant's telephone number, including area code)

Not Applicable

(Former name, former address and former fiscal year, if changed since last report)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the Registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. YES x NO ¨

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulations S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required

to submit and post such files). YES x NO ¨

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See definitions of “large accelerated filer,” “accelerated filer” and “smaller reporting company” in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer	¨	Accelerated filer	x
Non-accelerated filer	¨	Smaller reporting company	¨

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). YES ¨ NO x

The number of shares of the registrant’s common stock, par value $0.001 per share, outstanding as of July 31, 2013 was 18,415,995 shares.

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EHEALTH, INC. FORM 10-Q

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PART I

FINANCIAL INFORMATION

ITEM 1. FINANCIAL STATEMENTS

EHEALTH, INC.

CONDENSED CONSOLIDATED BALANCE SHEETS

(In thousands)

	December 31, 2012	June 30, 2013 (unaudited)
Assets		
Current assets:		
Cash and cash equivalents	$ 140,849	$ 89,713
Accounts receivable	4,468	5,334
Deferred income taxes	4,098	6,434
Prepaid expenses and other current assets	6,643	7,141
Total current assets	156,058	108,622
Property and equipment, net	6,185	9,482
Deferred income taxes	2,928	4,413
Other assets	8,123	6,257
Intangible assets, net	8,911	8,204
Goodwill	14,096	14,096
Total assets	$ 196,301	$ 151,074

Liabilities and stockholders' equity		
Current liabilities:		
Accounts payable	$ 6,123	$ 5,446
Accrued compensation and benefits	8,244	7,726
Accrued marketing expenses	3,941	3,367
Deferred revenue	926	1,546
Other current liabilities	1,575	2,613
Total current liabilities	20,809	20,698
Non-current liabilities	4,625	5,978
Stockholders' equity:		
Common stock	27	28
Additional paid-in capital	232,903	241,951
Treasury stock, at cost	(90,991)	(149,998)
Retained earnings	28,743	32,250
Accumulated other comprehensive income	185	167
Total stockholders' equity	170,867	124,398
Total liabilities and stockholders' equity	$ 196,301	$ 151,074

The accompanying notes are an integral part of these condensed consolidated financial statements.

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EHEALTH, INC.

CONDENSED CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

(In thousands, except per share amounts, unaudited)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2013	2012	2013
Revenue				
Commission	$ 30,603	$ 34,942	$ 62,067	$ 73,193
Other	4,904	4,858	10,515	9,814
Total revenue	35,507	39,800	72,582	83,007
Operating costs and expenses:				
Cost of revenue	764	984	2,439	3,635
Marketing and advertising	12,167	13,761	25,154	28,596
Customer care and enrollment	6,358	7,812	12,329	14,978
Technology and content	5,033	7,727	10,515	14,468
General and administrative	6,590	7,132	13,194	14,651
Amortization of intangible assets	460	353	907	707
Total operating costs and expenses	31,372	37,769	64,538	77,035
Income from operations	4,135	2,031	8,044	5,972
Other income (expense), net	16	(21)	37	(46)
Income before provision for income taxes	4,151	2,010	8,081	5,926
Provision for income taxes	1,846	864	3,651	2,419
Net income	$ 2,305	$ 1,146	$ 4,430	$ 3,507
Net income per share:				
Basic	$ 0.12	$ 0.06	$ 0.23	$ 0.18
Diluted	$ 0.11	$ 0.06	$ 0.22	$ 0.17
Weighted-average number of shares used in per share amounts:				
Basic	19,624	18,946	19,580	19,754
Diluted	20,497	19,496	20,471	20,324
Comprehensive income:				
Net income	$ 2,305	$ 1,146	$ 4,430	$ 3,507
Foreign currency translation adjustment	-	(15)	(2)	(18)
Comprehensive income	$ 2,305	$ 1,131	$ 4,428	$ 3,489

The accompanying notes are an integral part of these condensed consolidated financial statements.

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EHEALTH, INC.

CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

(In thousands, unaudited)

	Six Months Ended June 30,	
	2012	2013
Operating activities		
Net income	$ 4,430	$ 3,507
Adjustments to reconcile net income to net cash provided by operating activities:		
Deferred income taxes	(142)	(3,449)
Depreciation and amortization	1,114	1,390
Amortization of book-of-business consideration	1,418	2,548
Amortization of intangible assets	907	707
Stock-based compensation expense	2,987	3,416
Deferred rent	(17)	827
Changes in operating assets and liabilities:		
Accounts receivable	4,394	(866)
Prepaid expenses and other assets	(1,142)	(1,176)
Accounts payable	1,356	(1,541)
Accrued compensation and benefits	(1,572)	(530)
Accrued marketing expenses	(3,039)	(575)
Deferred revenue	88	887
Other current liabilities	1,943	952
Net cash provided by operating activities	12,725	6,097
Investing activities		
Purchases of property and equipment	(2,146)	(3,821)
Consideration paid in connection with book-of-business transfers	(6,243)	-
Net cash used in investing activities	(8,389)	(3,821)
Financing activities		
Net proceeds from exercise of common stock options	2,370	2,549
Cash used to net-share settle equity awards	(986)	(842)
Excess tax benefits from stock-based compensation	1,187	3,926
Repurchase of common stock	(8,441)	(59,007)

Principal payments in connection with capital leases	(18)	(26)
Net cash used in financing activities	(5,888)	(53,400)
Effect of exchange rate changes on cash and cash equivalents	-	(12)
Net decrease in cash and cash equivalents	(1,552)	(51,136)
Cash and cash equivalents at beginning of period	123,607	140,849
Cash and cash equivalents at end of period	$ 122,055	$ 89,713

The accompanying notes are an integral part of these condensed consolidated financial statements.

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EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

Note 1 - Summary of Business and Significant Accounting Policies

Description of Business—eHealth, Inc. (the "Company," "eHealth," "we" or "us") is the leading online source of health insurar for individuals, families and small businesses in the United States. Through our website addresses (www.eHealth.com, www.eHealthInsurance.com, www.eHealthMedicare.com and www.PlanPrescriber.com), consumers can get quotes from leading health insurance carriers, compare plans side-by-side, and apply for and purchase individual and family, Medicare-related, small business and ancillary health insurance plans. We actively market the availability of Medicare-related insurance plans and offer Medicare plan comparison tools and educational materials for Medicare-related insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. Our ecommerce technology also enables us to deliver consumers' health insurance applications electronically to health insurance carriers. As a result, we simplify and streamline the complex and traditionally paper-intensive health insurance sales and purchasing process. We are licensed to market and sell health insurance in all 50 states and the District of Columbia.

Basis of Presentation—The accompanying condensed consolidated balance sheet as of June 30, 2013, the condensed consolidated statements of comprehensive income for the three and six months ended June 30, 2012 and 2013 and the condensed consolidated statements of cash flows for the six months ended June 30, 2012 and 2013, respectively, are unaudited. The condensed consolidated balance sheet data as of December 31, 2012 was derived from the audited consolidated financial statements included in our Annual Report on Form 10-K for the year ended December 31, 2012, which was filed with the Securities and Exchange Commission on March 13, 2013. The accompanying statements should be read in conjunction with the audited consolidated financial statements and related notes contained in our Annual Report on Form 10-K.

The accompanying condensed consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles, or U.S. GAAP, for interim financial information. Accordingly, they do not include all of the financial information and footnotes required by U.S. GAAP for complete financial statements. The unaudited condensed consolidated financial statements have been prepared on the same basis as the audited consolidated financial statements in our Annual Report on Form 10-K for the year ended December 31, 2012, and include all adjustments necessary for the fair presentation of eHealth's statement of financial position as of June 30, 2013, its results of operations for the three and six months ended June 30, 2012 and 2013 and its cash flows for the six months ended June 30, 2012 and 2013. All adjustments are of a normal recurring nature. The property and equipment balance on the June 30, 2013 condensed consolidated balance sheet includes $0.9 million of leasehold improvements that are not included in the purchases of property and equipment balance in the condensed consolidated statement of cash flows for the six months ended June 30, 2013 because the amounts had not been paid as of June 30, 2013. The results for the three and six months ended June 30, 2013 are not necessarily indicative of the results to be expected for any subsequent period or for the fiscal year ending December 31, 2013.

Seasonality—The number of individual and family health insurance applications submitted through our ecommerce platform has generally increased in our first quarter compared to our fourth quarter and in our third quarter compared to our second quarter. Conversely, we have generally experienced a decline or flattening of individual and family submitted applications in our second quarter compared to our first quarter and in our fourth quarter compared to our third quarter. The majority of Medicare plans are sold in our fourth quarter during the Medicare annual enrollment period, when Medicare-eligible individuals are permitted to change their Medicare Advantage and Medicare Part D prescription drug coverage for the following year. As a result, we generate a significant amount of Medicare plan-related revenue in the fourth quarter of the year. Additionally, we recognize a majority of our renewal Medicare Advantage and Medicare Part D prescription drug plan commission revenue in the first quarter of each year as the majority of policies sold during the annual enrollment period typically renew on January 1 of each year.

Since a significant portion of our marketing and advertising expenses are driven by the number of health insurance applications submitted on our ecommerce platform, those expenses are influenced by these patterns. As a result, marketing and advertising expenses related to individual and family health insurance plans are highest in our first and third quarters, while marketing and advertising expenses related to Medicare-related plans are highest in our third and fourth quarters. Additionally, in preparation for the Medicare annual enrollment period, we begin ramping up our temporary customer care center staff during our second and third quarters and employ our temporary customer care center staff until the end of the Medicare annual enrollment period in December. Accordingly, our customer care center staffing costs are significantly higher in our third and fourth quarters compared to our first and second quarters.

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EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—CONTINUED

Recently Adopted Accounting Standards—Effective January 1, 2013, we adopted an accounting standards update with new guidance on the presentation of reclassifications from accumulated other comprehensive income to net income. This standard requires an entity to present reclassifications from accumulated other comprehensive income to net income either on the face of the condensed consolidated financial statements or in the notes to the condensed consolidated financial statements. In the six months ended June 30, 2013 we did not have any reclassifications from accumulated other comprehensive income to net income.

Note 2 – Cash, Cash Equivalents and Accounts Receivable

Cash and Cash Equivalents—As of December 31, 2012 and June 30, 2013, our cash equivalents consisted of money market accounts that invested in U.S. government-sponsored enterprise bonds and discount notes, U.S. government treasury bills and notes and repurchase agreements collateralized by U.S. government obligations. At December 31, 2012 and June 30, 2013, our cash equivalents carried no unrealized gains or losses and we did not realize any significant gains or losses on sales of cash equivalents during the three and six months ended June 30, 2012 and 2013.

As of December 31, 2012 and June 30, 2013, our cash and cash equivalent balances were invested as follows (in thousands):

	December 31, 2012	June 30, 2013
Cash	$ 27,484	$ 17,594
Money market funds	113,365	72,119
Total cash and cash equivalents	$ 140,849	$ 89,713

We used observable prices in active markets in determining the classification of our money market funds as Level 1 as of December 31, 2012 and June 30, 2013.

Accounts Receivable—As of December 31, 2012 and June 30, 2013, our accounts receivable consisted of the following (in thousands):

	December 31, 2012	June 30, 2013
Accounts receivable - from other revenues	$ 3,319	$ 1,552
Commissions receivable	1,149	3,782
Total accounts receivable	$ 4,468	$ 5,334

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EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—CONTINUED

Note 3 – Stockholders' Equity

Stock Plans—The following table summarizes activity under our 2006 Equity Incentive Plan, 1998 Stock Plan and 2005 Stock Plan (collectively, the "Stock Plans") (in thousands):

	Shares Available for Grant
Shares available for grant December 31, 2012 (1)	3,982
Additional shares authorized (2)	818
Restricted stock units granted	(561)
Options granted	(78)
Restricted stock units cancelled	17
Options cancelled	49
Shares available for grant June 30, 2013 (1)	4,227

(1) Shares available for grant do not include treasury stock shares that could also become available for grant if we determined to do so.

(2) On January 1, 2013, the number of shares authorized for issuance under the 2006 Equity Incentive Plan was automatically increased pursuant to the terms of the 2006 Equity Incentive Plan.

The following table summarizes stock option activity under the Stock Plans (in thousands, except per share amounts and weighted average remaining contractual life data):

Number of Stock Options	Weighted Average Exercise	Weighted-Average Remaining Contractual Life (years)	Aggregate Intrinsic Value (1)

		Price		
Balance outstanding at December 31, 2012	2,956	$ 13.41	3.91	$ 41,642
Granted	78	$ 19.26		
Exercised	(694)	$ 3.67		
Cancelled	(49)	$ 18.23		
Balance outstanding at June 30, 2013	2,291	$ 16.46	4.39	$ 14,827
Vested and expected to vest at June 30, 2013	2,221	$ 16.42	4.34	$ 14,445
Exercisable at June 30, 2013	1,430	$ 15.97	3.62	$ 9,929

(1) The aggregate intrinsic value is calculated as the difference between eHealth's closing stock price as of December 31, 2012 and June 30, 2013 and the exercise price of in-the-money options as of those dates.

The total grant date fair value of stock options vested during the three and six months ended June 30, 2012 was $0.5 million and $1.4 million, respectively. The total grant date fair value of stock options vested during the three and six months ended June 30, 2013 was $0.7 million and $2.0 million, respectively.

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EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—CONTINUED

The following table summarizes restricted stock unit activity, including performance-based restricted stock unit activity, under the Stock Plans (in thousands, except weighted average remaining contractual life data):

	Number Outstanding	Weighted-Average Remaining Contractual Life (years)	Aggregate Intrinsic Value (1)
Balance outstanding as of December 31, 2012	381	2.22	$ 10,464
Granted	561		
Vested	(163)		
Cancelled	(17)		
Balance outstanding as of June 30, 2013	762	2.62	$ 17,306

(1) The aggregate intrinsic value is calculated as eHealth's closing stock price as of December 31, 2012 and June 30, 2013 multiplied by the number of restricted stock units outstanding as of December 31, 2012 and June 30, 2013, respectively.

The fair value of the restricted stock units is based on eHealth's stock price on the date of grant, and compensation expense related to these awards is recognized on a straight-line basis over the vesting period. The fair value of performance-based restricted stock units is based on eHealth's stock price on the date of grant, and compensation expense related to these awards is recognized on an accelerated basis over the vesting period. The total grant date fair value of restricted stock units vested during the three and six months ended June 30, 2012 was $1.1 million and $3.7 million, respectively. The total grant date fair value of restricted stock units vested during the three and six months ended June 30, 2013 was $1.2 million and $3.2 million, respectively.

Stock Repurchase Programs—On September 10, 2012, we announced that our board of directors approved a stock repurchase program authorizing us to purchase up to $30 million of our common stock and on March 6, 2013, we announced that our board of directors increased the approved repurchase amount under this program to $60 million. Purchases under this program were made in the open market and complied with Rule 10b-18 under the Securities Exchange Act of 1934, as amended. The cost of the repurchased shares was funded from available working capital.

For accounting purposes, common stock repurchased under our stock repurchase programs is recorded based upon the settlement date of the applicable trade. Such repurchased shares are held in treasury and are presented using the cost method.

Stock repurchase activity under our stock repurchase programs during the six months ended June 30, 2013 is summarized as follows (dollars in thousands, except share and per share amounts):

	Total Number of Shares Repurchased	Average Price Paid per Share (2)	Amount of Repurchase
Cumulative balance at December 31, 2012 (1)	6,397,803	$ 14.22	$ 90,991
Repurchases of common stock during 2013	2,911,466	$ 20.27	59,007
Cumulative balance at June 30, 2013 (1)	9,309,269	$ 16.11	$ 149,998

(1) Cumulative balances at December 31, 2012 and June 30, 2013 consist of shares repurchased in connection with our stock repurchase program announced on September 10, 2012, as well as previous stock repurchase plans announced in 2011, 2010 and 2008.
(2) Average price paid per share includes commissions.

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EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—CONTINUED

In addition to the shares repurchased under our repurchase programs as of June 30, 2013, we have in treasury 206,435 shares that were previously surrendered by employees to satisfy tax withholdings due in connection with the vesting of certain restricted stock units. As of December 31, 2012 and June 30, 2013, we had a total of 6,556,303 million shares and 9,515,704 million shares, respectively, held in treasury.

Stock-Based Compensation—The fair value of stock options granted to employees for the three and six months ended June 30, 2012 and 2013 was estimated using the following weighted average assumptions:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2013	2012	2013
Expected term	4.7 years	4.3 years	4.7 years	4.3 years
Expected volatility	44.4%	39.7%	44.4%	39.7%
Expected dividend yield	0%	0%	0%	0%
Risk-free interest rate	0.94%	0.62%	0.94%	0.62%
Weighted-average fair value	$ 6.40	$ 6.32	$ 6.40	$ 6.32

The following table summarizes stock-based compensation expense recorded during the three and six months ended June 30, 2012 and 2013 (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2013	2012	2013
Common stock options	$ 674	$ 656	$ 1,365	$ 1,448
Restricted stock units	688	1,126	1,622	1,968
Total stock-based compensation expense	$ 1,362	$ 1,782	$ 2,987	$ 3,416

The following table summarizes stock-based compensation expense by operating function for the three and six months ended June 30, 2012 and 2013 (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2013	2012	2013
Marketing and advertising	$ 362	$ 470	$ 602	$ 929
Customer care and enrollment	74	81	153	169
Technology and content	218	385	551	704
General and administrative	708	846	1,681	1,614
Total stock-based compensation expense	$ 1,362	$ 1,782	$ 2,987	$ 3,416

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EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—CONTINUED

Note 4 – Income Taxes

The following table summarizes our provision for income taxes and our effective tax rates for the three and six months ended June 30, 2012 and 2013 (in thousands, except effective tax rate):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2013	2012	2013
Income before provision for income taxes	$ 4,151	$ 2,010	$ 8,081	$ 5,926
Provision for income taxes	$ 1,846	$ 864	$ 3,651	$ 2,419
Effective tax rate	44.5%	43.0%	45.2%	40.8%

Our effective tax rate in the three and six months ended June 30, 2012 was higher than statutory federal and state tax rates due primarily to non-deductible lobbying expenses and tax shortfalls related to share-based payments. Our effective tax rate in the three and six months ended June 30, 2013 was higher than statutory federal and state tax rates due primarily to non-deductible lobbying expenses, partially offset by a tax benefit resulting from the recent extension of the federal research tax credit through December 31, 2013.

During the three and six months ended June 30, 2012, we utilized excess federal and state tax benefits related to share-based payments, which resulted in increases of $0.6 million and $1.2 million, respectively, in Additional Paid-In Capital in the condensed consolidated balance sheets. During the three and six months ended June 30, 2013, we utilized excess federal and state tax benefits related to share-based payments, which resulted in increases of $0.5

million and $3.9 million, respectively, in Additional Paid-In Capital in the condensed consolidated balance sheets. These amounts are also classified in the condensed consolidated statements of cash flows as both a reduction to operating cash flows and as a financing cash inflow.

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EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—CONTINUED

Note 5 – Net Income Per Share

Basic net income per share is computed by dividing net income by the weighted-average number of common shares outstanding for the period (excluding shares subject to repurchase). Diluted net income per share is computed by dividing the net income for the period by the weighted average number of common and common equivalent shares outstanding during the period. Diluted net income per share is computed giving effect to all potential dilutive common stock equivalent shares, including options, restricted stock and restricted stock units. The dilutive effect of outstanding awards is reflected in diluted net income per share by application of the treasury stock method.

The following table sets forth the computation of basic and diluted net income per share (in thousands, except per share amounts):

	Three Months Ended		Six Months Ended	
	June 30, 2012	2013	June 30, 2012	2013
Basic:				
Numerator:				
Net income allocated to common stock	$ 2,305	$ 1,146	$ 4,430	$ 3,507
Denominator:				
Weighted average number of common stock shares	19,624	19,532	20,118	21,019
Weighted average number of common stock shares repurchased	-	(586)	(538)	(1,265)
Net weighted average number of common stock shares outstanding	19,624	18,946	19,580	19,754
Net income per share—basic:	$ 0.12	$ 0.06	$ 0.23	$ 0.18
Diluted:				
Numerator:				
Net income allocated to common stock	$ 2,305	$ 1,146	$ 4,430	$ 3,507

Denominator:				
Net weighted average number of common stock shares outstanding	19,624	18,946	19,580	19,754
Weighted average number of options	789	445	774	453
Weighted average number of restricted stock units	84	105	117	117
Total common stock shares used in per share calculation	20,497	19,496	20,471	20,324
Net income per share—diluted:	$ 0.11	$ 0.06	$ 0.22	$ 0.17

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EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—CONTINUED

For each of the three- and six- month periods ended June 30, 2012 and 2013, we had securities outstanding that could potentially dilute net income per share, but the shares from the assumed exercise of these securities were excluded in the computation of diluted net income per share as their effect would have been anti-dilutive. The number of outstanding weighted average anti-dilutive shares that were excluded from the computation of diluted net income per share consisted of the following (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2013	2012	2013
Common stock options	1,466	290	1,507	312
Restricted stock units	-	12	-	6
Total	1,466	302	1,507	318

Note 6 – Geographic Information and Significant Customers

Geographic Information—As of December 31, 2012 and June 30, 2013, our long-lived assets consisted primarily of property and equipment, goodwill and other indefinite-lived intangible assets and finite-lived intangible assets. Our long-lived assets are attributed to the geographic location in which they are located. Long-lived assets by geographical area were as follows (in thousands):

	As of December 31, 2012	As of June 30, 2013

United States	$ 37,037	$ 37,726
China	278	313
Total	$ 37,315	$ 38,039

Significant Customers—Substantially all revenue for the three and six months ended June 30, 2012 and 2013 was generated from customers located in the United States. Carriers representing 10% or more of our total revenue in the three and six months ended June 30, 2012 and 2013 are presented in the table below:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2013	2012	2013
Humana	13%	17%	15%	20%
WellPoint (1)	15%	13%	13%	12%
UnitedHealthcare (2)	14%	11%	13%	11%

(1) Wellpoint also includes other carriers owned by Wellpoint.
(2) UnitedHealthcare also includes other carriers owned by UnitedHealthcare.

Commission revenue attributable to major medical individual and family health insurance plans was approximately 79% and 78% of our commission revenue in the three and six months ended June 30, 2012, respectively. Commission revenue attributable to major medical individual and family health insurance plans was approximately 75% and 70% of our commission revenue in the three and six months ended June 30, 2013, respectively. We define our individual and family plan offerings as major medical individual and family health insurance plans, which do not include small business, Medicare-related health insurance plan offerings and other ancillary products such as short-term, stand-alone dental, life, vision, accident and student insurance plan offerings.

As of December 31, 2012, four customers represented 25%, 22%, 14% and 11%, respectively, for a combined total of 72% of our $4.5 million outstanding accounts receivable balance. As of June 30, 2013, one customer represented 68% of our $5.3 million outstanding accounts receivable balance. No other customers represented 10% or more of our total accounts

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EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—CONTINUED

receivable at December 31, 2012 and June 30, 2013. We believe the potential for collection issues with any of our customers is minimal as of June 30, 2013. Accordingly, our estimate for uncollectible amounts at June 30, 2013 was not material.

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ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

In addition to historical information, this Quarterly Report on Form 10-Q contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934. These statements include, among other things, statements regarding our expectations relating to revenue (including commission revenue, lead referral revenue, advertising revenue and other revenue), sources of revenue, cost of revenue, the collectability of our accounts receivable and our estimate of accounts receivable as of June 30, 2013, profitability, operating expenses, marketing and advertising expenses, customer care and enrollment employees and expenses, technology and content expenses, general and administrative expenses; our future commission rate structure; our overall individual and family health insurance commission rate structure, the timing of our recognition of a majority of our first year Medicare Advantage and Medicare Part D prescription drug plan commission revenue, an increase in our commission revenue in absolute dollars in 2013 relative to 2012, the amount of fees we pay to marketing partners for consumer referrals that result in submitted health insurance applications, seasonal and absolute increases in our customer care and enrollment costs, increases in technology and content expenses, increases in general and administrative expenses, our estimate of the number of continuing members on all policies, our significant accounting policies, the sufficiency of our cash generated from operations and our current cash and cash equivalents, the comparability of member retention rates and the commissions that health insurance carriers pay in connection our sale of individual and family health insurance; the advantages of a long-standing provision of each state’s law relating to health insurance premiums; our intention to perform services for substantially all Medicare leads as a health insurance agent; the seasonality of our business and financial results; the timing and amount of our future lease obligations; the impact of health care reform laws on the health insurance industry and on our business; the timing of health care reform open enrollment periods and readiness therefore; our plans and expectations relating to our Medicare business and factors impacting its success; impact of medical loss ratio regulations and commission rate changes; our expectations and projections relating to membership and commission rates; the timing and source of our Medicare-related revenue; estimates relating to critical accounting policies and related impact on our financial statements; the sufficiency of our cash and cash equivalents; future capital requirements; our projections relating to future revenue growth and earnings per share; our future competitors; expansion into new business areas and additional geographic regions; our need for additional regulatory licenses and approvals; as well as other statements regarding our future operations, financial condition, prospects and business strategies. These forward-looking statements are subject to certain risks and uncertainties that could cause our actual results to differ materially from those reflected in the forward-looking statements. Factors that could cause or contribute to such differences include, but are not limited to, those discussed in this report, and in particular, the risks discussed under the heading “Risk Factors” in Part II, Item 1A of this report and those discussed in our other Securities and Exchange Commission filings. The following discussion should be read in conjunction with our Annual Report on Form 10-K as filed with the Securities and Exchange Commission in March 2013, and the audited consolidated financial statements and related notes contained therein. We undertake no obligation to revise or publicly release the results of any revision to these forward-looking statements. Given these risks and uncertainties, you are cautioned not to place undue reliance on such forward-looking statements.

Overview

We are the leading online source of health insurance for individuals, families and small businesses. Through our website addresses (www.eHealth.com, www.eHealthInsurance.com, www.eHealthMedicare.com and

www.PlanPrescriber.com), consumers can get quotes from leading health insurance carriers, compare plans side-by-side, and apply for and purchase individual and family, Medicare-related, small business and ancillary health insurance plans. Our ecommerce technology also enables us to deliver consumers' health insurance applications electronically to health insurance carriers. As a result, we simplify and streamline the complex and traditionally paper-intensive health insurance sales and purchasing process.

We have invested heavily in technology and content related to our ecommerce platform. We have also invested significant time and resources in obtaining licenses to sell health insurance in all 50 states and the District of Columbia, developing diverse member acquisition programs, obtaining necessary regulatory approvals of our websites and establishing relationships and appointments with over 200 leading insurance carriers, enabling us to offer thousands of health insurance plans online. Our ecommerce platforms can be accessed directly through our website as well as through our network of marketing partners.

We generate revenue primarily from commissions we receive from health insurance carriers whose health insurance policies are purchased through our ecommerce platform. Commission revenue represented 86% of total revenue in the three and six months ended June 30, 2012 and represented 88% of total revenue in the three and six months ended June 30, 2013.

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The commission payments we receive for individual and family, small business and ancillary health insurance policies are typically a percentage of the premium on the health insurance policy that we sold and are typically made to us on a monthly basis for as long as the policy remains active with us.

We actively market the availability of Medicare-related health insurance plans through our online Medicare plan platforms www.eHealthMedicare.com and www.PlanPrescriber.com. Our Medicare plan platforms enable consumers to research and compare Medicare-related health insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. Commission payments we receive for Medicare Advantage and Medicare Part D prescription drug plans sold by us are typically fixed and are earned over a period of up to six years, or longer depending on the carrier arrangement, and are paid to us either monthly or annually. Medicare commissions we receive are included in commission revenue.

As a result of our commission structure, much of our revenue for a given financial reporting period relates to health insurance plans that we sold prior to the beginning of the period and is recurring in nature. Additionally, health insurance pricing, which is set by the health insurance carrier and approved by regulators, is not subject to negotiation or discounting by health insurance carriers or our competitors.

In March 2010, the federal Patient Protection and Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act were signed into law. These health care reform laws contain provisions that have and will continue to change the health insurance industry in substantial ways. Among several other provisions, they and the regulations implementing them include a mandate requiring individuals to maintain health insurance or face tax penalties; a mandate that certain employers offer and contribute to their employees group health insurance coverage or face tax penalties if they do not do so in 2015 and thereafter; prohibitions against insurance companies using pre-existing health conditions as a reason to deny an application for health insurance; requirements for minimum individual and small business health insurance benefit levels, including prohibitions on lifetime coverage limits and limitations on annual coverage limits; medical loss ratio requirements that require each health insurance carrier to spend a certain percentage of their premium revenue on reimbursement for clinical services and activities that improve health care quality; establishment of state and/or federal government-run health insurance exchanges to facilitate access to, and the purchase of, health insurance; open enrollment periods for the purchase of individual health insurance during specified times of the year; Medicaid expansion so that a greater number of individuals will be insured under Medicaid programs; and subsidies and cost-sharing credits to make health insurance more affordable for those below certain income levels if they are eligible and purchase individual or small group health insurance through the state or federal health insurance exchange.

Many aspects of health care reform become effective in 2014. Health insurance carriers have been required as a part of health care reform to maintain medical loss ratios of eighty percent in their individual and family health insurance business since the beginning of 2011. The implementation of the medical loss ratio requirements by insurance carriers has resulted in a reduction in the commission rates that we are paid as a result of our selling individual and family health insurance plans. These commission rate changes began to impact our individual and family health insurance plan commission-based revenue in 2011. The implementation of an eighty-five percent medical loss ratio requirement for Medicare Advantage plans is scheduled to be implemented in 2014, and it is unclear what impact that implementation will have on our commission rates, if any.

While aspects of health care reform may positively impact our business, the aggregate future impact of the implementation of health care reform on our business and financial results is uncertain. For instance, it is unclear how

our existing members will react to health care reform and whether they will seek or be forced to purchase new health insurance products once health insurance carriers implement new health insurance plans or change existing plans in response to health care reform requirements. Our ability to continue to act as a health insurance agent for our members who switch to a new health insurance product will be dependent upon a number of factors, including health insurance company practices, individual financial circumstances, our members' existing health insurance plans, the price of health insurance and our ability to expand our offering to include subsidy-eligible health insurance plans. In order to be eligible for a subsidy, qualified individuals must purchase subsidy-qualifying health plans through a government-run health insurance exchange. These qualified health plans are required to be purchased during an initial open enrollment period scheduled to begin in October 2013 and run through March 2014. While a large number of consumers may enter the market for individual health insurance in response to health care reform given the requirement that individuals maintain health insurance or face a tax penalty, it is unclear whether the tax penalty will have this intended effect, particularly if health insurance carriers significantly increase the cost of health insurance in response to health care reform. Moreover, we will face new competition in the form of government-run health insurance exchanges and our ability to act as a health insurance agent to health care reform subsidy-eligible individuals is dependent upon permission from state health insurance exchanges and upon health insurance companies to allow us to sell subsidy-eligible health insurance plans and to pay us commissions in connection

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with their sale. Permission from government-run health insurance exchanges will be conditioned on our satisfying a number of requirements relating to the display of information on our websites as well as new and comprehensive privacy and security requirements. Our ability to meet these and other significant requirements in a short time frame could present significant challenges for us. The implementation of open enrollment periods for the purchase of individual health insurance also presents challenges to our ability to enroll a significant number of individuals into health insurance over a limited period of time. The impact of health care reform on our health insurance carrier partners and their reaction is also unclear. For instance, health insurance carriers have the ability to unilaterally change their relationship with us, including the commission rates we receive for acting as a health insurance agent and may reduce the amount they pay us, alter the manner and geographic areas in which they permit us to sell their products and change our relationship with them in any number of ways. Given the disruption that the implementation of health care reform may have on the health insurance market, health care reform could in the aggregate have a material adverse effect on our business and results of operations.

We derive revenue from our online sponsorship and advertising program that allows carriers to purchase advertising space in specific markets in a sponsorship area on our website. In return, we are typically paid a monthly fee and a performance-based fee based on metrics such as submitted health insurance applications. We also offer Medicare advertising services, which allow Medicare plan carriers to purchase advertising on a separate website developed, hosted and maintained by us. In these instances, we are typically paid a fixed, up-front fee, which we recognize as revenue over the service period.

We derive revenue from licensing the use of our health insurance ecommerce technology and typically receive a fixed, up-front fee or performance-based fees, or a combination of both. Our technology platform enables health insurance carriers and agents to market and distribute health insurance plans online. We also have licensed our ecommerce technology for use by government agencies.

In the past we also derived a significant amount of revenue from referral fees paid to us based on leads generated by our online platforms that are delivered and sold to third parties. In early 2012 we began directly servicing most of the Medicare leads we generated as a health insurance agent, while significantly reducing the number of Medicare leads we sold to third parties. As a result, our lead referral revenue declined significantly in 2013 compared to 2012. To the extent that we assist in the sale of Medicare-related insurance plans as a health insurance agent, we generate revenue from commissions we receive from health insurance carriers, rather than one-time referral fees we receive for the sale of Medicare leads.

Sources of Revenue

Commission Revenue

We generate revenue primarily from commissions we receive from health insurance carriers whose health insurance policies are purchased through us. Commissions for individual and family, small business and ancillary health insurance policies, such as stand-alone dental, life, student, vision, accident and short-term insurance plan offerings, have generally represented a percentage of the insurance premium and, to a much lesser extent, commission

override payments that insurance carriers pay us for achieving sales volume thresholds or other objectives. Commission rates vary by carrier and by the type of plan purchased by a member. Commission rates can vary based upon the amount of time that the policy has been active, with commission rates for individual and family plans typically being higher in the first twelve months of the policy. After the first twelve months, commission rates generally decline significantly. As a result, if we do not add a sufficient number of members on new policies, our revenue growth will be negatively impacted. Individuals, families and small businesses purchasing health insurance through us typically pay their premiums on a monthly basis. Insurance carriers typically pay commissions to us on these policies monthly, after they receive the premium payment from the member. We generally continue to receive the commission payment from the relevant insurance carrier until the health insurance policy is cancelled or we otherwise do not remain the agent on the policy. As a result, the majority of our commission revenue is recurring in nature.

Major medical individual and family health insurance plans do not include small business or Medicare-related health insurance plan offerings and do not include other ancillary products such as stand-alone dental, life, student, vision, accident and short-term insurance plan offerings. Our individual and family health insurance plan commission revenue has been adversely impacted due to the reduction in the commission rates that we are paid on new policies sold subsequent to the implementation of the medical loss ratio requirements beginning in 2011 as a result of health care reform legislation. Commission rate changes due to the implementation of the medical loss ratio requirements applied prospectively to applicable commissions earned on or after January 1, 2011 and the majority of the changes applied only to commissions earned on new individual and family plan members approved in 2011 and thereafter.

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We have increased our efforts to sell ancillary health insurance products, which include stand-alone dental, life, student, vision, accident and short-term insurance plan offerings, both in conjunction with the sale of an individual and family health insurance plan, as well as on a stand-alone basis,

We define a member as an individual covered by an insurance plan, including individual and family, Medicare-related, small business and ancillary plans, for which we are entitled to receive compensation. For the majority of individual and family plan members that were approved prior to the effective date of the commission rate changes, we are being paid commissions at the rates in effect prior to the changes. As a result, the adverse impact to our overall individual and family health insurance commission rate structure is being phased in as the number of members approved after the commission rate changes becomes a greater proportion of our individual and family plan membership. Although we believe our overall individual and family health insurance commission rate structure has stabilized from the adverse impact caused by the implementation of the medical loss ratio requirements, our actual future individual and family commission rate structure will depend on the total number of our individual and family plan members, the mix between individual and family plan members approved prior to the commission rate changes and those approved after the changes, any future changes to commission rates, including any changes that result from the implementation of major aspects of health care reform in 2014, and the mix of new approved members by state, health insurance carrier and type of health plan, among other factors. Additionally, other programs that health insurance carriers have supported, such as commission overrides and our sponsorship and advertising programs, have also been reduced as carriers look to reduce costs to comply with the new medical loss ratio requirements.

We generally recognize individual and family, small business and ancillary health insurance plan revenue when commissions are reported to us by a health insurance carrier, net of an estimate for future forfeiture amounts payable to carriers due to policy cancellations. Commissions are reported to us by a cash payment and commission statement. We generally receive these communications simultaneously. In instances when we receive the cash payment and commission statement separately and in different accounting periods, we recognize revenue in the period that we receive the earliest communication, provided we receive the second corroborating communication shortly after the end of the accounting period. If the second corroborating communication is not received shortly after the end of the accounting period, we recognize revenue in the period the second communication is received. We use the data in the commission statements to help identify the members for which we are receiving a commission payment and the amount received for each member, and to estimate forfeitures payable to carriers. As a result, we recognize the net amount of compensation earned as the agent in the transaction. Commission override revenue, which we recognize on the same basis as premium commissions, is generally reported to us in a more irregular pattern than premium commissions. As a result, our revenue for a particular quarter could be higher or lower than expectations due to the timing of the reporting of commission override revenue to us.

Under the federal Patient Protection and Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act, health insurance plans are required to be purchased by individuals, families and small businesses through government-run health insurance exchanges during an initial open enrollment period scheduled to begin in October 2013 and run through March 2014 in order for the individual, family or small business to receive subsidies from the government. Subsidy-eligible individuals, families and small businesses can thereafter change their qualified health plan only during annual enrollment periods scheduled to occur from October 15 through December 7

of each year thereafter, subject to states extending the period and exceptions for special enrollment periods for certain qualifying events. Moreover, some health insurance carriers and states have adopted, and others may adopt, open enrollment periods for the sale of health insurance outside of these exchanges. To the extent states allow us to market subsidy-eligible health plans and to the extent states or health insurance carriers adopt open enrollment periods for the sale of individual and family and small business health insurance in general, we will experience additional seasonality in both our sales volumes and expenses as a result of the enrollment period.

We actively market the availability of Medicare-related insurance plans through our online Medicare plan platforms, including (www.eHealthMedicare.com and www.PlanPrescriber.com). These platforms enable consumers to research and compare Medicare-related insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. We offer online application and telephonic enrollment capabilities for certain Medicare plans. To the extent that we assist in the sale of Medicare-related insurance plans as a health insurance agent, through either online applications or telephonically, we generate revenue from commissions we receive from health insurance carriers. The commission payments we receive for Medicare Supplement plans are typically a percentage of the premium on the policy that we sold and are paid to us on a monthly basis for as long as a policy remains active with us. For both Medicare Advantage and Medicare Part D prescription drug plans, we receive a fixed, annual commission from insurance carriers after the policy is approved by the carrier and either a fixed, monthly commission beginning with and subsequent to the second policy year for a Medicare Advantage policy or a fixed, annual commission beginning with and subsequent to the

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second policy year for a Medicare Part D prescription drug policy. Additionally, these commission rates may be higher in the first twelve months of a policy if the policy is the first Medicare-related policy issued to the member. We may earn commission revenue for both Medicare Advantage and Medicare Part D prescription drug plans typically for a period of up to six years, or longer depending on the carrier arrangement, provided that the policy remains active with us.

We recognize commission revenue for both Medicare Advantage and Medicare Part D prescription drug plans for the entire policy year once the annual or first monthly commission amount for the policy year is reported to us by the carrier, net of an estimate for future forfeiture amounts due to policy cancellations. For commissions paid to us on a monthly basis, we record a receivable for the commission amounts to be received over the remainder of the policy year, net of an estimate for commission amounts not expected to be collected due to policy cancellations, which is included in Accounts Receivable in the accompanying condensed consolidated balance sheets. We continue to receive the commission payments from the relevant insurance carrier until the earlier of the cancellation of the policy, our no longer remaining the agent on the policy, or our commission term with the carrier expires, typically up to six years from the effective date of the policy, or longer depending on the carrier arrangement. We determine that there is persuasive evidence of an arrangement when we have a commission agreement with a health insurance carrier. Our services are complete when a carrier has approved an application in the initial year and when a member has renewed in a renewal year. The seller's price is fixed or determinable and collectability is reasonably assured when a carrier has approved an application and the carrier reports to us the annual or first monthly renewal commission amount for each policy year.

We expect to recognize a majority of our first year Medicare Advantage and Medicare Part D prescription drug plan commission revenue in the fourth quarter of each year as a result of the Medicare annual enrollment period, which occurs in the fourth quarter of each year. Additionally, we recognize a majority of our renewal Medicare Advantage and Medicare Part D prescription drug plan commission revenue in the first quarter of each year as the majority of policies sold during the annual enrollment period typically renew on January 1 of each year.

Commission revenue attributable to major medical individual and family health insurance plans was 79% and 78% of commission revenue in the three and six months ended June 30, 2012, respectively, and was 75% and 70% of commission revenue in the three and six months ended June 30, 2013, respectively. The decline in the percentage of commission revenue attributable to major medical individual and family health insurance plans in the three and six months ended June 30, 2013, compared to the three and six months ended June 30, 2012, was due primarily to an increase in commission revenue attributable to both ancillary health insurance plans, consisting primarily of dental, accident and vision insurance plan offerings, and Medicare-related insurance plans.

We expect commission revenue to increase in absolute dollars in 2013 compared to 2012, primarily as a result of an increase in Medicare-related commission revenue, and to a lesser extent, increases in both individual and family plan and ancillary plan commission revenues.

Other Revenue

In addition to the commission revenue we derive from the sale of health insurance plans, we derive other revenue from our online sponsorship and advertising program, from licensing the use of our ecommerce technology and from generating and delivering leads, primarily for Medicare plans.

Online Sponsorship and Advertising. We offer advertising services for our Medicare plan carriers to purchase advertising on separate websites developed, hosted and maintained by us for a pre-determined amount of time. In these instances, we are typically paid a fixed, up-front fee, which we recognize as revenue over the service period. We also derive revenue from online sponsorship and advertising programs that allows carriers to purchase advertising space in specific markets in a sponsorship area on our website. In return, we are typically paid a monthly fee and a performance-based fee based on metrics such as submitted health insurance applications.

Technology Licensing. We derive revenue from licensing the use of our health insurance ecommerce technology. Our technology platform enables health insurance carriers and agents to market and distribute health insurance plans online. In our technology licensing business, we are paid implementation fees and performance-based fees that are based on metrics such as submitted health insurance applications. Typically, we are paid a one-time implementation fee commencing once the technology is available for use by the third party, which we recognize on a straight-line basis over the term of the agreement. In addition, we generate revenue based on performance criteria that are either measured based on data tracked by us, or based on data tracked by the third party. In instances where the performance criteria data are tracked by us, we recognize revenue in the period of performance. In instances where the performance criteria data are tracked by the third

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party, we recognize revenue when the amounts earned are fixed or determinable and collection is reasonably assured. Typically, this occurs through our receipt of a cash payment from the third party along with a detailed statement containing the data that is tracked by the third party.

Medicare Lead Referral. Our online Medicare plan platforms (www.eHealthMedicare.com and www.PlanPrescriber.com) enable consumers to research and compare Medicare-related insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. The Medicare-related revenue we have generated includes referral fees paid to us based on Medicare leads generated by our online platforms that are delivered and sold to third parties. Prior to 2012, the majority of our lead referral revenue was generated during the Medicare annual enrollment period, which occurs during the fourth quarter of the calendar year. In the second quarter of 2012, we began to perform services for substantially all Medicare leads ourselves as a health insurance agent, for which we are entitled to receive commissions. As a result, our Medicare lead referral revenue declined substantially. In the future, we intend to continue to perform services for substantially all Medicare leads ourselves as a health insurance agent.

We expect other revenue to decline in absolute dollars in 2013 compared to 2012 due primarily to a decrease in Medicare lead referral revenue as a result of our strategic decision to directly service most of the Medicare leads we generate as a health insurance agent, while significantly reducing the number of Medicare leads we sell to third parties. As a result of this decision, we expect Medicare-related commission revenue to continue to increase in 2013. We also expect the decline in Medicare lead referral revenue to be partially offset by an increase in online sponsorship and advertising revenue.

Member Acquisition

An important factor in our revenue growth is the growth of our member base. Our marketing initiatives are an important component of our strategy to grow our member base and are focused on three primary member acquisition channels: direct, marketing partners and online advertising. Our marketing initiatives are primarily designed to encourage consumers to complete an application for health insurance. Our marketing channels are as follows:

Direct. Our direct member acquisition channel consists of consumers who access our website addresses, including www.eHealth.com, www.eHealthInsurance.com, www.eHealthMedicare.com and www.PlanPrescriber.com, either directly or through algorithmic natural search listings on Internet search engines and directories. For the three and six months ended June 30, 2012, applications submitted through us for individual and family health insurance from our direct channel constituted 47% and 45%, respectively, of all individual and family health insurance applications submitted on our website. For the three and six months ended June 30, 2013, applications submitted through us for individual and family health insurance from our direct channel constituted 49% and 48%, respectively, of all individual and family health insurance applications submitted on our website.

Marketing Partners. Our marketing partner member acquisition channel consists of consumers who access our websites through a network of affiliate partners and financial services and other companies. Growth in our marketing partner channel depends upon our expanding marketing programs with existing partners and adding new partners to our network. For the three and six months ended June 30, 2012, applications submitted through us for individual and family health insurance plans from our marketing partner member acquisition channel constituted approximately 31% and 32%, respectively, of all individual and family health insurance applications submitted on our website. For both the three and six months ended June 30, 2013, applications submitted through us for individual and family health insurance plans from our marketing partner member acquisition channel constituted approximately 32% of all individual and family health insurance applications submitted on our website.

Online Advertising. Our online advertising member acquisition channel consists of consumers who access our websites through paid keyword search advertising from search engines such as Google, Bing and Yahoo!, as well as various Internet marketing programs such as banner advertising and email marketing. For the three and six months ended June 30, 2012, applications submitted through us for individual and family health insurance plans from our online advertising channel constituted approximately 22% and 23%, respectively, of all individual and family health insurance applications submitted on our website. For the three and six months ended June 30, 2013, applications submitted through us for individual and family health insurance plans from our online advertising channel constituted approximately 19% and 20%, respectively, of all individual and family health insurance applications submitted on our website.

In addition to our marketing channels, we have acquired Medicare members through transactions with a broker partner. We have entered into several agreements, whereby the partner has transferred certain of its existing Medicare plan members

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to us as the broker of record on the underlying policies. The first of these transferred books-of-business occurred in November 2010 and the most recent in June 2012.

Operating Costs and Expenses

Cost of Revenue

Included in cost of revenue are payments related to health insurance policies sold to members who were referred to our website by marketing partners with whom we have revenue-sharing arrangements. In order to enter into a revenue-sharing arrangement, marketing partners must be licensed to sell health insurance in the state where the policy is sold. Costs related to revenue-sharing arrangements are expensed as the related revenue is recognized.

Additionally, cost of revenue includes the amortization of consideration we paid to certain broker partners in connection with the transfer of their health insurance members to us as the new broker of record on the underlying policies. These transfers include primarily Medicare plan members. Total consideration paid in connection with these transfers amounted to $13.9 million. Consideration for all book-of-business transfers is being amortized to cost of revenue as we recognize commission revenue related to the transferred members over a period of up to five years for each arrangement.

We expect cost of revenue to increase in absolute dollars in 2013 compared to 2012 due to an increase in the amortization of consideration we paid to certain broker partners in connection with the transfer of their health insurance members to us as the new broker of record on the underlying policies.

Marketing and Advertising

Marketing and advertising expenses consist primarily of member acquisition expenses associated with our direct, marketing partner and online advertising member acquisition channels, in addition to compensation and other expenses related to marketing, business development, partner management, public relations and carrier relations personnel who support our offerings. Our direct channel expenses primarily consist of costs for e-mail marketing and may also include costs for television advertising, radio advertising, print advertising, direct mail and email marketing.

Our marketing partner channel expenses consist primarily of fees paid to marketing partners with which we have a relationship. We compensate a significant number of our marketing partners by paying a fee each time a consumer referral from a partner results in a submitted health insurance application, regardless of whether the consumer's application is approved by the health insurance carrier. Many of our marketing partners have tiered arrangements in which the amount of the fee increases as the volume of submitted applications we receive from the marketing partner increases over a particular period. We recognize these expenditures in the period when a marketing partner's referral results in the submission of a health insurance application. The number of individual and family health insurance applications submitted through our ecommerce platform has generally increased in our first quarter compared to our fourth quarter and in our third quarter compared to our second quarter. Conversely, we have generally experienced a decline or flattening in individual and family submitted applications in our second quarter compared to our first quarter and in our fourth quarter compared to our third quarter. The impact the newly implemented open enrollment period for the purchase of major medical health insurance plans will have on our member acquisition channels is unclear, although we expect that the seasonal patterns for individual and family plan submitted applications will be impacted. The next open enrollment period is scheduled to begin in October 2013 and run through March 2014, and then is scheduled to occur within the fourth quarter of each calendar year starting in 2014. We also expect total marketing expenses will increase to some extent during the open enrollment period as consumers switch to subsidy-eligible policies.

The majority of Medicare plans are sold in our fourth quarter during the Medicare annual enrollment period, when Medicare-eligible individuals are permitted to change their Medicare Advantage and Medicare Part D prescription drug coverage for the following year. Since a significant portion of our marketing and advertising expenses are driven by the number of health insurance applications submitted on our website, those expenses are influenced by these patterns. In addition, because the total volume of submitted applications that we receive from our marketing partners is largely outside of our control, particularly during any short-term period, and because of our tiered marketing partner arrangements, we could incur expenses in excess of, or below, the amounts we had planned in periods of rapid change in the volume of submitted applications from marketing partner referrals. An unanticipated increase in submitted applications resulting from marketing partner referrals could cause our net income to be lower than our expectation, since the revenue to be derived from submitted applications that are approved by health insurance carriers will not be recognized until future periods.

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Paid keyword search advertising on search engines represents the majority of expenses in our online advertising channel. We incur expenses associated with search engine advertising in the period in which the consumer clicks on the advertisement. Similar to our marketing partner channel, expenses in our online advertising channel will increase or decrease in relation to any increase or decrease in consumers referred to our website as a result of search engine advertising. For example, due to the substantial increase in the number of consumers referred to our website from paid keyword search advertising during the Medicare annual enrollment period in the fourth quarter of 2012, we experienced a significant increase in online advertising expenses during the fourth quarter of 2012 compared to the other quarters of 2012. We also increased our discretionary spending for Medicare plan-related online advertising in the third and fourth quarters of 2012, compared to first and second quarters, in conjunction with the Medicare annual enrollment period in the fourth quarter of 2012. Because the majority of our Medicare plan-related revenue is not generated until the fourth quarter, our discretionary online advertising expenses had a negative impact on our profitability during the third quarter of 2012. These seasonal patterns also occurred in 2011 and we expect them to occur again in 2013.

We expect our marketing and advertising expenses to increase in absolute dollars in 2013 compared to 2012 due primarily to an increase in our Medicare-related online marketing and advertising expenditures during 2013, including paid keyword search advertising. We also expect our marketing and advertising expenses to decline as a percentage of total revenue in 2013 compared to 2012 as the growth rate in total revenue is expected to be higher than the growth rate in marketing and advertising expenses.

Customer Care and Enrollment

Customer care and enrollment expenses primarily consist of compensation and benefits costs for personnel engaged in pre-sales assistance to applicants who call our customer care center and for enrollment personnel who assist applicants during the underwriting process. Beginning in the second quarters of 2012 and 2013, we hired, trained and obtained health insurance licenses and health insurance carrier appointments for additional employees in our customer care centers to service the increase in the volume of Medicare leads we received in the fourth quarter of 2012 and that we expect to receive in the fourth quarter of 2013 as a result of the Medicare annual enrollment period. Many of these additional customer care center employees are temporary and their employment terminates at or near the conclusion of the Medicare annual enrollment period in December. As a result of our temporary customer care center staffing requirements, we expect our customer care and enrollment costs to be higher in the third and fourth quarters of each year compared to the first and second quarters. Because the majority of our Medicare plan-related revenue is not generated until the fourth quarter, our temporary customer care center staffing costs incurred in the third quarter has had a significant negative impact on our profitability during that quarter. We expect these seasonal trends to continue in 2013.

We expect customer care and enrollment expenses to increase in absolute dollars in 2013 compared to 2012 as a result of additional personnel we have hired and expect to hire to service the expected increase in the volume of Medicare demand in 2013 and due to an increase in expenditures to further develop our Medicare plan sales capabilities.

Technology and Content

Technology and content expenses consist primarily of compensation and benefits costs for personnel associated with developing and enhancing our website technology as well as maintaining our website. A majority of our technology and content group is located at our wholly-owned subsidiary in China, where technology development costs are generally lower than in the United States.

In order for us to offer and sell subsidy-eligible health insurance plans on our websites, we are required to meet certain conditions, such as compliance with standards for display of health plan and related information; providing consumers the ability to view all subsidy-eligible plans offered on the state's exchange; displaying all subsidy-eligible health plan data on the state's exchange; and providing a mechanism for consumers to withdraw from the application process to the state exchange. We are increasing our technology and content spending throughout 2013 in order to increase functionality to meet the conditions required to offer and sell subsidy-eligible health insurance plans and to enhance the user experience.

We expect technology and content expenses to increase in absolute dollars and as a percentage of total revenue in 2013 compared to 2012 as a result of an increase in labor and personnel costs in our product management and engineering departments as we increase our investment in our technology platform to further enhance the user experience, increase functionality and meet the requirements to offer and sell subsidy-eligible health insurance plans.

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General and Administrative

General and administrative expenses include compensation and benefits costs for staff working in our executive, finance, corporate development, investor relations, government affairs, legal, human resources, internal audit, facilities and internal information technology departments. These expenses also include fees paid for outside professional services, including audit, tax, legal, government affairs and information technology fees.

We expect our general and administrative expenses to increase in absolute dollars in 2013 compared to 2012 as we add infrastructure to support company growth.

Summary of Selected Metrics

The following table shows certain selected quarterly metrics for the three months ended June 30, 2012 and 2013 and as of June 30, 2012 and 2013:

Key Metrics:	Three Months Ended June 30, 2012	Three Months Ended June 30, 2013
Operating cash flows (1)	$ 7,632,000	$ 6,635,000
IFP submitted applications (2)	103,400	110,600
IFP approved members (3)	87,900	100,700
Total approved members (4)	148,500	190,400
Commission revenue (5)	$ 30,603,000	$ 34,942,000
Commission revenue per estimated member for the period (6)	$ 35.47	$ 32.58
	As of June 30, 2012	As of June 30, 2013
IFP estimated membership (7)	684,000	748,000
Medicare estimated membership (8)	42,900	80,400
Other estimated membership (9)	150,000	263,000
Total estimated membership (10)	876,900	1,091,400

Other Metrics:	Three Months Ended June 30, 2012	Three Months Ended June 30, 2013
Source of IFP submitted applications (as a percentage of total IFP applications for the period):		
Direct (11)	47%	49%
Marketing partners (12)	31%	32%
Online advertising (13)	22%	19%
Total	100%	100%

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Notes:

(1) Net cash provided by operating activities for the period from the condensed consolidated statements of cash flows.
(2) IFP applications submitted on eHealth's website during the period. Applications are counted as submitted when the applicant completes the application, provides a method for payment and clicks the submit button on our website and submits the application to us. The applicant generally has additional actions to take before the application will be reviewed by the insurance carrier, such as providing additional information and providing an electronic signature. In addition, an applicant may submit more than one application. We include applications for IFP plans for which we receive commissions as well as other forms of payment. We define our "IFP" offerings as major medical individual and family health insurance plans, which does not include small business, short-term, stand-alone dental, life, student or Medicare-related health insurance plans.
(3) New IFP members reported to eHealth as approved during the period. Some members that are approved by a carrier do not accept the approval and therefore do not become paying members.
(4) New members for all products reported to eHealth as approved during the period. Some members that are approved by a carrier do not accept the approval and therefore do not become paying members.
(5) Commission revenue (from all sources) recognized during the period from the condensed consolidated statements of comprehensive income.
(6) Calculated as commission revenue recognized during the period (see note (5) above) divided by average estimated membership for the period (calculated as beginning and ending estimated membership for all plans for the period, divided by two).
(7) Estimated number of members active on IFP insurance policies as of the date indicated.
(8) Estimated number of members active on Medicare-related insurance policies as of the date indicated.
(9) Estimated number of members active on insurance policies other than IFP and Medicare-related policies as of the date indicated.
(10) Estimated number of members active on all insurance policies, including Medicare-related policies, as of the date indicated.
(11) Percentage of IFP submitted applications from applicants who came directly to the eHealth website through algorithmic search engine results or otherwise. See note (2) above for further information as to what constitutes a submitted application.
(12) Percentage of IFP submitted applications from applicants sourced through eHealth's network of marketing partners. See note (2) above for further information as to what constitutes a submitted application.
(13) Percentage of IFP submitted applications from applicants sourced through paid search and other online advertising activities. See note (2) above for further information as to what constitutes a submitted application.

Our insurance carrier partners bill and collect insurance premiums paid by our members. Carrier partners do not report to us the number of members that we have as of a given date. The majority of our non-Medicare members who terminate their policies do so by discontinuing their premium payments to the carrier and do not inform us of the cancellation. Also, some of our non-Medicare members pay their premiums less frequently than monthly. Given the number of months required to observe non-payment of commissions in order to confirm cancellations, we estimate the number of members who are active on insurance policies as of a specified date. We estimate the number of continuing members on all policies as of a specific date as follows:

- For individual and family health insurance policies, we take the sum of (i) the number of members for whom we have received or applied a commission payment for the month that is six months prior to the date of estimation (after reducing that number using historical experience for assumed member cancellations over the six-month period); and (ii) the number of approved members over the six-month period prior to the date of estimation (after reducing that number using historical experience for an assumed number of members who do not accept their approved policy and for estimated member cancellations through the date of the estimate).

- For ancillary insurance policies (such as short-term, dental, vision, accident and student), we take the sum of (i) the number of members for whom we have received or applied a commission payment for the month that is one to three months prior to the date of estimation (after reducing that number using historical experience for assumed member cancellations over the one to three-month period); and (ii) the number of approved members over the one to three-month period prior to the date of estimation (after reducing that number using historical experience for an assumed number of members who do not accept their approved policy and for estimated member cancellations through the date of the estimate). The one to three-month period varies by insurance product and is largely dependent upon the timeliness of commission payment and related reporting from the related carriers.

- For Medicare-related insurance policies, we take the number of members for whom we have received or applied a commission payment prior to the date of estimation (after reducing that number using historical experience for assumed member cancellations, including rapid disenrollment).

- For small business health insurance policies, we estimate the number of members using the number of initial members at the time the group is approved, and we update this number for changes in membership if such

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changes are reported to us by the group or carrier in the period it is reported. However, groups generally notify the carrier directly of policy cancellations and increases or decreases in group size without informing us. Additionally, our carrier partners often do not communicate this information to us. We often are made aware of policy cancellations at the time of annual renewal and update our membership statistics accordingly in the period they are reported.

As a result, a member who purchases and is active on multiple standalone insurance policies will be counted as a member more than once. For example, a member who is active on both an individual and family health insurance policy and a standalone dental policy will be counted as two continuing members.

After we have estimated membership for a period, we may receive information from health insurance carriers that would have impacted the estimate if we had received the information prior to the date of estimation. We may receive commission payments or other information that indicates that a member who was not included in our estimates for a prior period was in fact an active member at that time, or that a member who was included in our estimates was in fact not an active member of ours. For instance, we reconcile information carriers provide to us and may determine that we were not historically paid commissions owed to us, which would cause us to have underestimated our membership. Conversely, carriers may require us to return commission payments paid in a prior period due to policy cancellations for members we previously estimated as being active. We reflect updated information regarding our membership in the membership estimate for the current period that we are estimating, if applicable. As a result of the delay in our receipt of information from insurance carriers, actual trends in our membership are most discernible over periods longer than from one quarter to the next. In addition, and as a result of the delay we experience in receiving information about our membership, it is difficult for us to determine with any certainty the impact of current economic and other conditions on our membership retention.

Critical Accounting Policies and Estimates

The preparation of financial statements and related disclosures in conformity with U.S. generally accepted accounting principles, or U.S. GAAP, requires us to make judgments, assumptions, and estimates that affect the amounts reported in the consolidated financial statements and the accompanying notes. These estimates and assumptions are based on current facts, historical experience, and various other factors that we believe are reasonable under the circumstances to determine reported amounts of assets, liabilities, revenue and expenses that are not readily apparent from other sources. To the extent there are material differences between our estimates and the actual results, our future consolidated results of operations may be affected.

An accounting policy is considered to be critical if the nature of the estimates or assumptions is material due to the levels of subjectivity and judgment necessary to account for highly uncertain matters or the susceptibility of such matters to change, and the effect of the estimates and assumptions on financial condition or operating performance. The accounting policies we believe to reflect our more significant estimates, judgments and assumptions and are most critical to understanding and evaluating our reported financial results are as follows:

" Revenue Recognition;
" Stock-Based Compensation;

" Realizability of Long-Lived Assets; and
" Accounting for Income Taxes.

During the three and six months ended June 30, 2013, there were no significant changes to our critical accounting policies and estimates. Please refer to Management's Discussion and Analysis of Financial Condition and Results of Operations contained in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2012, for a complete discussion of our critical accounting policies and estimates.

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Results of Operations

The following table sets forth our operating results and the related percentage of total revenues for the three and six months ended June 30, 2012 and 2013 (dollars in thousands):

	Three Months Ended June 30,				Six Months Ended June 30,			
	2012		2013		2012		2013	
Revenue:								
Commission	$ 30,603	86 %	$ 34,942	88 %	$ 62,067	86 %	$ 73,193	88 %
Other	4,904	14	4,858	12	10,515	14	9,814	12
Total revenue	35,507	100	39,800	100	72,582	100	83,007	100
Operating costs and expenses:								
Cost of revenue	764	2	984	2	2,439	3	3,635	4
Marketing and advertising	12,167	34	13,761	35	25,154	35	28,596	34
Customer care and enrollment	6,358	18	7,812	20	12,329	17	14,978	18
Technology and content	5,033	14	7,727	19	10,515	14	14,468	17
General and administrative	6,590	19	7,132	18	13,194	18	14,651	18
Amortization of intangible assets	460	1	353	1	907	1	707	1
Total operating costs and expenses	31,372	88	37,769	95	64,538	89	77,035	93
Income from operations	4,135	12	2,031	5	8,044	11	5,972	7
Interest and other income (expense), net	16	0	(21)	(0)	37	0	(46)	(0)
Income before provision for income taxes	4,151	12	2,010	5	8,081	11	5,926	7
Provision for income taxes	1,846	5	864	2	3,651	5	2,419	3
Net income	$ 2,305	6 %	$ 1,146	3 %	$ 4,430	6 %	$ 3,507	4 %

Operating costs and expenses include the following amounts of stock-based compensation expense (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2013	2012	2013
Marketing and advertising	$ 362	$ 470	$ 602	$ 929
Customer care and enrollment	74	81	153	169
Technology and content	218	385	551	704
General and administrative	708	846	1,681	1,614
Total stock-based compensation expense	$ 1,362	$ 1,782	$ 2,987	$ 3,416

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Three and Six Months Ended June 30, 2012 and 2013

Revenue

The following table presents our commission, other revenue and total revenue for the three and six months ended June 30, 2012 and 2013 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2012	2013	$	%	2012	2013	$	%
Commission	$ 30,603	$ 34,942	$ 4,339	14%	$ 62,067	$ 73,193	$ 11,126	18%
Percentage of total revenue	86%	88%			86%	88%		
Other	$ 4,904	$ 4,858	$ (46)	(1%)	$ 10,515	$ 9,814	$ (701)	(7%)
Percentage of total revenue	14%	12%			14%	12%		
Total revenue	$ 35,507	$ 39,800	$ 4,293	12%	$ 72,582	$ 83,007	$ 10,425	14%

Three Months Ended June 30, 2012 and 2013—Commission revenue increased in the three months ended June 30, 2013, compared to the three months ended June 30, 2012, due primarily to a $1.9 million increase in commission revenue related to individual and family plans, including commission overrides. Additionally, commission revenue related to ancillary health insurance products, consisting primarily of dental, accident and vision insurance plan offerings, increased $1.5 million and Medicare-related commission revenue increased $1.0 million. Medicare-related commission revenues increased due primarily to an increase in renewals of Medicare plans we sold in prior years. Additionally, Medicare-related commission revenues increased due to an increase in the number of Medicare plans we sold.

Other revenue decreased in the three months ended June 30, 2013, compared to the three months ended June 30, 2012, due primarily to a decrease in Medicare-related health insurance product lead referral revenue. The decrease in lead referral revenue was the result of our strategic decision to reduce the number of Medicare leads sold to third parties and to instead act as a health insurance agent to those leads. As health insurance agent, we are entitled to receive on-going commission revenue related to the sale of a health insurance policy, compared to a one-time referral fee for the sale of a lead. The decrease in Medicare lead revenue was partially offset by an increase in online sponsorship and advertising revenue.

Six Months Ended June 30, 2012 and 2013—Commission revenue increased in the six months ended June 30, 2013, compared to the six months ended June 30, 2012, due primarily to a $5.3 million increase in Medicare-related commission revenue, which was driven primarily by Medicare plan renewals, for which the first quarter is the highest volume quarter of each year. Additionally, Medicare-related commission revenues increased due to an increase in the number of Medicare plans we sold. Commission revenue related to individual and family plans, including commission overrides, increased $3.1 million and commission revenue related to ancillary health insurance products, consisting primarily of dental, accident and vision insurance plan offerings, increased $2.7 million.

Other revenue decreased in the six months ended June 30, 2013, compared to the six months ended June 30, 2012, due primarily to a decrease in Medicare-related health insurance product lead referral revenue, partially offset by an increase in online sponsorship and advertising revenue.

Operating Costs and Expenses

Cost of Revenue

The following table presents our cost of revenue for the three and six months ended June 30, 2012 and 2013 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2012	2013	$	%	2012	2013	$	%
Cost of revenue	$ 764	$ 984	$ 220	29%	$ 2,439	$ 3,635	$ 1,196	49%
Percentage of total revenue	2%	2%			3%	4%		

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Three Months Ended June 30, 2012 and 2013—Cost of revenue increased in the three months ended June 30, 2013, compared to the three months ended June 30, 2012, due primarily to an increase in amortization expense associated with consideration we paid in connection with several book-of-business transactions in which we acquired broker of record status on a number of Medicare health insurance plans. The amount of book-of-business consideration we amortize to cost of revenue each quarter is proportional to the amount of commission revenue we recognize on the underlying policies each quarter.

Six Months Ended June 30, 2012 and 2013—Cost of revenue increased in the six months ended June 30, 2013, compared to the six months ended June 30, 2012, due primarily to an increase in amortization expense associated with consideration we paid in connection with several book-of-business transactions in which we acquired broker of record status on a number of Medicare health insurance plans. The amount of book-of-business consideration we amortize to cost of revenue each period is proportional to the amount of commission revenue we recognize on the underlying policies each period.

Marketing and Advertising

The following table presents our marketing and advertising expenses for the three and six months ended June 30, 2012 and 2013 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2012	2013	$	%	2012	2013	$	%
Marketing and advertising	$ 12,167	$ 13,761	$ 1,594	13%	$ 25,154	$ 28,596	$ 3,442	14%
Percentage of total revenue	34%	35%			35%	34%		

Three Months Ended June 30, 2012 and 2013—Marketing and advertising expenses increased in the three months ended June 30, 2013 compared to the three months ended June 30, 2012, due primarily to an increase of $1.4 million in advertising expenses, including fees we pay to marketing partners for referrals that result in the submission of a health insurance application on our website, direct online advertising costs and paid keyword search advertising costs on Internet search engines. Additionally, compensation, benefits, stock-based compensation and other personnel costs increased $0.2 million as a result of an increase in marketing and advertising personnel.

Six Months Ended June 30, 2012 and 2013—Marketing and advertising expenses increased in the six months ended June 30, 2013 compared to the six months ended June 30, 2012, due primarily to an increase of $2.6 million in advertising expenses, including fees we pay to marketing partners for referrals that result in the submission of a health insurance application on our website, direct online advertising costs and paid keyword search advertising costs on Internet search engines. Additionally, compensation, benefits, stock-based compensation and other personnel costs increased

$0.8 million as a result of an increase in marketing and advertising personnel.

Customer Care and Enrollment

The following table presents our customer care and enrollment expenses for the three and six months ended June 30, 2012 and 2013 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2012	2013	$	%	2012	2013	$	%
Customer care and enrollment	$ 6,358	$ 7,812	$ 1,454	23%	$ 12,329	$ 14,978	$ 2,649	21%
Percentage of total revenue	18%	20%			17%	18%		

Three Months Ended June 30, 2012 and 2013—Customer care and enrollment expenses increased in the three months ended June 30, 2013 compared to the three months ended June 30, 2012, due primarily to additional customer care center

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personnel hired to service the increase in volume of Medicare leads serviced directly by us as a health insurance agent. As a result, compensation, benefits, stock-based compensation and other personnel costs increased $1.2 million and insurance licensing costs increased $0.1 million.

Six Months Ended June 30, 2012 and 2013—Customer care and enrollment expenses increased in the six months ended June 30, 2013 compared to the six months ended June 30, 2012, due primarily to additional customer care center personnel hired to service the increase in volume of Medicare leads serviced directly by us as a health insurance agent. As a result, compensation, benefits, stock-based compensation and other personnel costs increased $2.1 million and insurance licensing costs increased $0.1 million.

Technology and Content

The following table presents our technology and content expenses for the three and six months ended June 30, 2012 and 2013 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2012	2013	$	%	2012	2013	$	%
Technology and content	$ 5,033	$ 7,727	$ 2,694	54%	$ 10,515	$ 14,468	$ 3,953	38%
Percentage of total revenue	14%	19%			14%	17%		

Three Months Ended June 30, 2012 and 2013—Technology and content expenses increased in the three months ended June 30, 2013 compared to the three months ended June 30, 2012, primarily due to an increase of $2.2 million in compensation, benefits, stock-based compensation and other personnel costs as a result of an increase in technology and content personnel. Additionally, equipment maintenance costs increased $0.2 million.

Six Months Ended June 30, 2012 and 2013—Technology and content expenses increased in the six months ended June 30, 2013 compared to the six months ended June 30, 2012, primarily due to an increase of $3.6 million in compensation, benefits, stock-based compensation and other personnel costs as a result of an increase in technology and content personnel. Additionally, equipment maintenance costs increased $0.3 million.

General and Administrative

The following table presents our general and administrative expenses for the three and six months ended June 30, 2012 and 2013 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2012	2013	$	%	2012	2013	$	%
General and administrative	$ 6,590	$ 7,132	$ 542	8%	$ 13,194	$ 14,651	$ 1,457	11%
Percentage of total revenue	19%	18%			18%	18%		

Three Months Ended June 30, 2012 and 2013—General and administrative expenses increased in the three months ended June 30, 2013 compared to the three months ended June 30, 2012, due primarily to an increase of $0.4 million in compensation, benefits, stock-based compensation and other personnel costs as a result of an increase in general and administrative personnel as we add infrastructure to support company growth.

Six Months Ended June 30, 2012 and 2013—General and administrative expenses increased in the six months ended June 30, 2013 compared to the six months ended June 30, 2012, due primarily to an increase of $1.2 million in compensation, benefits, stock-based compensation and other personnel costs as a result of an increase in general and administrative personnel as we add infrastructure to support company growth.

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Amortization of Intangible Assets

The following table presents our amortization of intangible assets for the three and six months ended June 30, 2012 and 2013 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2012	2013	$	%	2012	2013	$	%
Amortization of intangible assets	$ 460	$ 353	$ (107)	(23%)	$ 907	$ 707	$ (200)	(22%)
Percentage of total revenue	1%	1%			1%	1%		

Three and Six Months Ended June 30, 2012 and 2013—Amortization expense related to intangible assets purchased through our acquisition of PlanPrescriber decreased in the three and six months ended June 30, 2013 compared to the three and six months ended June 30, 2012, respectively, as certain intangible assets were fully amortized during 2012.

Other Income (Expense), Net

The following table presents our other income (expense), net, for the three and six months ended June 30, 2012 and 2013 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2012	2013	$	%	2012	2013	$	%
Other income (expense), net	$ 16	$ (21)	$ (37)	(231%)	$ 37	$ (46)	$ (83)	(224%)
Percentage of total revenue	0%	(0%)			0%	(0%)		

Three and Six Months Ended June 30, 2012 and 2013—Interest earned on our invested cash more than offset administrative bank fees, investment management fees and interest expense on our capital leases in the three and six

months ended June 30, 2012. Administrative bank fees, management fees and interest expense on our capital lease obligations more than offset interest earned on our invested cash in the three and six months ended June 30, 2013.

Provision for Income Taxes

The following table presents our provision for income taxes for the three and six months ended June 30, 2012 and 2013 and the dollar changes from the prior year periods (dollars in thousands):

	Three Months Ended June 30,			Six Months Ended June 30,		
	2012	2013	Change $	2012	2013	Change $
Provision for income taxes	$ 1,846	$ 864	$ (982)	$ 3,651	$ 2,419	$ (1,232)
Percentage of total revenue	5%	2%		5%	3%	

Three Months Ended June 30, 2012 and 2013—In the three months ended June 30, 2012 and 2013, we recorded a provision for income taxes representing effective tax rates of 44.5% and 43.0%, respectively. Our effective tax rate for the three months ended June 30, 2012 was higher than statutory federal and state tax rates due primarily to non-deductible lobbying expenses and tax shortfalls related to share-based payments. Our effective tax rate for the three months ended June 30, 2013 was higher than statutory federal and state tax rates due primarily to non-deductible lobbying expenses.

Six Months Ended June 30, 2012 and 2013—In the six months ended June 30, 2012 and 2013, we recorded a provision for income taxes representing effective tax rates of 45.2% and 40.8%, respectively. Our effective tax rate for the six months ended June 30, 2012 was higher than statutory federal and state tax rates due primarily to non-deductible lobbying expenses and tax shortfalls related to share-based payments. Our effective tax rate for the six months ended June 30, 2013 was higher than statutory federal and state tax rates due primarily to non-deductible lobbying expenses.

Liquidity and Capital Resources

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At June 30, 2013, our cash and cash equivalents totaled $89.7 million. Cash equivalents, which are comprised of financial instruments with an original maturity of 90 days or less from the date of purchase, primarily consist of money market funds. At December 31, 2012, our cash and cash equivalents totaled $140.8 million. The decrease in cash and cash equivalents reflects $59.0 million used to repurchase 2.9 million shares of common stock, partially offset by cash flows generated from operations.

On September 10, 2012, we announced that our board of directors approved a stock repurchase program authorizing us to purchase up to $30 million of our common stock and on March 6, 2013, we announced that our board of directors increased the approved repurchase amount under this program to $60 million. Purchases under this program were made in the open market and complied with Rule 10b-18 under the Securities Exchange Act of 1934, as amended. The cost of the repurchased shares was funded from available working capital.

For accounting purposes, common stock repurchased under our stock repurchase programs is recorded based upon the settlement date of the applicable trade. Such repurchased shares are held in treasury and are presented using the cost method.

Stock repurchase activity under our stock repurchase programs during the six months ended June 30, 2013 is summarized as follows (in thousands, except share and per share amounts):

	Total Number of Shares Repurchased	Average Price Paid per Share (2)	Amount of Repurchase
Cumulative balance at December 31, 2012 (1)	6,397,803	$ 14.22	$ 90,991
Repurchases of common stock	2,911,466	$ 20.27	59,007
Cumulative balance at June 30, 2013 (1)	9,309,269	$ 16.11	$ 149,998

(1) Cumulative balances at December 31, 2012 and June 30, 2013 consist of shares repurchased in connection with our stock repurchase programs announced on September 10, 2012, as well as previous stock repurchase plans announced in 2011, 2010 and 2008.
(2) Average price paid per share includes commissions.

In addition to the shares repurchased under our repurchase programs as of June 30, 2013, we have in treasury 206,435 shares that were previously surrendered by employees to satisfy tax withholdings due in connection with the vesting of certain restricted stock units. As of December 31, 2012 and June 30, 2013, we had a total of 6,556,303 million shares and 9,515,704 million shares, respectively, held in treasury.

The following table presents a summary of our cash flows for the six months ended June 30, 2012 and 2013 (in thousands):

	Six Months Ended June 30,	
	2012	2013
Net cash provided by operating activities	$ 12,725	$ 6,097
Net cash used in investing activities	$ (8,389)	$ (3,821)
Net cash used in financing activities	$ (5,888)	$ (53,400)

During the six months ended June 30, 2012 and 2013, we utilized excess federal and state tax benefits related to share-based payments, which resulted in increases of $1.2 million and $3.9 million, respectively, in Additional Paid-In Capital in the condensed consolidated balance sheets. These amounts are also classified in the condensed consolidated statements of cash flows as both a reduction to operating cash flows and as a financing cash inflow.

Operating Activities

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Cash provided by operating activities primarily consists of net income, adjusted for certain non-cash items including deferred income taxes, depreciation and amortization, including amortization of intangible assets, stock-based compensation expense and the effect of changes in working capital and other activities.

The timing of the recognition of our commission revenue depends upon the timing of our receipt of commission reports and associated commission payments from health insurance carriers. If we were to experience a delay in receiving a commission payment from a health insurance carrier at the end of a quarter, our operating cash flows for that quarter could be adversely impacted. Additionally, commission override payments are reported to us in a more irregular pattern than premium commissions. For example, a carrier may make a commission override payment to us on an annual basis, which would positively impact our cash flows in the quarter the payment is received. The annual commission override payments we receive are typically higher during the first quarter of the year.

Historically, we have experienced a reduction in operating cash flows during the first quarter of the year compared to the other quarters due to the payment of annual performance bonuses to employees in the first quarter of the year. In the first quarter of 2012, we collected a substantial amount of lead referral payments related to Medicare leads sold during the annual enrollment period in the fourth quarter of 2011. The seasonal impact of Medicare lead referral collections was minimal in 2013 as we have transitioned away from lead referral transactions. Additionally, a significant portion of our marketing and advertising expenses are driven by the number of health insurance applications submitted on our ecommerce platform. Since our marketing and advertising costs are expensed as incurred and the revenue from approved applications is recognized as commissions are subsequently reported to us, our operating cash flows could be adversely impacted by a substantial increase in the volume of applications submitted during a quarter or positively impacted by a substantial decline in the volume of applications submitted during a quarter. The impact of open enrollment periods beginning at the end of 2013 for the purchase of major medical health insurance plans will have on our future cash flows is unclear. The first open enrollment period is scheduled to begin in October 2013 and run through March 2014, and then is scheduled to occur within the fourth quarter each calendar year starting in 2014. We expect total marketing expenses will increase to some extent during the open enrollment period as consumers switch health insurance policies.

Six Months Ended June 30, 2013—Our operating activities generated cash of $6.1 million during the six months ended June 30, 2013 and consisted of net income of $3.5 million, increased by non-cash items of $5.4 million and offset by cash used in working capital and other activities of $2.8 million. Adjustments for non-cash items primarily consisted of $4.6 million of depreciation and amortization, including amortization of book-of-business consideration and amortization of intangible assets, and $3.4 million of stock-based compensation expense, partially offset by $3.4 million of deferred income taxes, consisting primarily of excess tax benefits from stock-based compensation. Cash used in working capital and other activities primarily consisted of a decrease of $1.5 million in accounts payable, an increase of $1.2 million in prepaid expenses and other assets, an increase of $0.9 million in accounts receivable, a decrease of $0.6 million in accrued marketing expenses and a decrease of $0.5 million in accrued compensation and other benefits, partially offset by an increase of $1.0 million in other current liabilities and an increase of $0.9 million in deferred revenue. Accounts payable decreased due to the timing of payments to our vendors and accrued compensation and benefits decreased primarily due to the payment of performance bonuses to employees that were earned during 2012.

Six Months Ended June 30, 2012—Our operating activities generated cash of $12.7 million during the six months ended June 30, 2012 and consisted of net income of $4.4 million, increased by non-cash items of $6.3 million and cash provided by working capital and other activities of $2.0 million. Adjustments for non-cash items primarily consisted $3.0 million of stock-based compensation expense and $3.4 million of depreciation and amortization, including amortization of book-of-business consideration and amortization of intangible assets. Cash provided by working capital and other activities primarily consisted of a decrease of $4.4 million in accounts receivable, an increase of $1.9 million in other current liabilities and an increase of $1.4 million in accounts payable, partially offset by a decrease of $3.0 million in accrued marketing expenses, an increase of $1.6 million in accrued compensation and benefits and an increase of $1.1 million in prepaid expenses and other assets. Accounts payable decreased due to the timing of payments to our vendors and accrued compensation and benefits decreased primarily due to the payment of performance bonuses to employees that were earned during 2011.

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Investing Activities

Our investing activities primarily consist of purchases of computer hardware and software to enhance our website and to support our growth and include consideration paid to a partner in connection with the transfer to us of certain Medicare plan members.

Six Months Ended June 30, 2013—Net cash used in investing activities of $3.8 million during the six months ended June 30, 2013 was attributable entirely to capital expenditures.

Six Months Ended June 30, 2012—Net cash used in investing activities of $8.4 million during the six months ended June 30, 2012 was attributable to cash consideration of $6.2 million paid to a partner related to the transfer of two books-of-business in the six months ended June 30, 2012, whereby we became the broker of record on the underlying policies for certain Medicare insurance members that were transferred to us, and capital expenditures of $2.1 million.

Financing Activities

Our financing activities primarily consist of net proceeds from the exercise of common stock options, cash used to net-share settle equity awards and excess tax benefits from stock-based compensation. Additionally, in periods in which we have an active stock repurchase program in effect, our financing activities include repurchases of common stock.

Six Months Ended June 30, 2013—Net cash used in financing activities of $53.4 million during the six months ended June 30, 2013 was due to $59.0 million used to repurchase 2.9 million shares of our common stock and $0.8 million used to net-share settle the tax obligation related to vesting equity awards, partially offset by $2.5 million of net proceeds from the exercise of common stock options and $3.9 million of excess tax benefits from stock-based compensation.

Six Months Ended June 30, 2012—Net cash used in financing activities of $5.9 million during the six months ended June 30, 2012 was due to $8.4 million used to repurchase 0.6 million shares of our common stock and $1.0 million used to net-share settle the tax obligation related to vesting equity awards, partially offset by $2.4 million of net proceeds from the exercise of common stock options and $1.2 million of excess tax benefits from stock-based compensation.

Future Needs

We believe that cash generated from operations and our current cash and cash equivalents will be sufficient to fund our operations for at least the next twelve months. Our future capital requirements will depend on many factors, including our level of investment in technology and advertising initiatives. We currently do not have any bank debt, line of credit facilities or other borrowing arrangements. To the extent that available funds are insufficient to fund our future activities, we may need to raise additional capital through public or private equity or debt financing to the extent such funding sources are available.

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Contractual Obligations and Commitments

Operating Lease Obligations

We lease certain of our office, operating facilities, equipment and furniture and fixtures under various operating leases, the latest of which expires in July 2023. Certain of these leases have free or escalating rent payment provisions. We recognize rent expense on our operating leases on a straight-line basis over the terms of the leases, although actual cash payment obligations under certain of these agreements fluctuate over the terms of the agreements.

In March 2012, we entered into an agreement to lease a building, being constructed in Mountain View, California, adjacent to our headquarters office. The term of the operating lease is ten years from the date the building is delivered to us and the base rent is approximately $0.6 million for the first year of the lease. The base rent increases annually by 3%. Future minimum payments related to this operating lease total $7.0 million over the ten-year term of the lease plus our proportionate share of certain operating expenses, insurance costs and taxes for each calendar year during the lease. Lease payments will begin in the third quarter of 2013.

Upon signing the Mountain View, California lease agreement, we entered into a financial guarantee consisting of a standby letter of credit for $0.6 million, which may be reduced in increments of 25% of the original amount thereof on the first, second and third anniversaries of the commencement date, subject to our compliance with the applicable conditions to such reductions set forth in the lease.

In April 2013, we entered into an agreement to lease approximately 20,000 square feet of office space in Westford, Massachusetts. The lease commences in July 2013 and is for a term of 5 years and 3 months. Future minimum payments will total approximately $2.1 million over the term of the lease.

Service and Licensing Obligations

We have entered into service and licensing agreements with third party vendors to provide various services, including network access, equipment maintenance and software licensing. The terms of these services and licensing agreements are generally up to three years. We record the related service and licensing expenses on a straight-line basis, although actual cash payment obligations under certain of these agreements fluctuate over the terms of the agreements.

The following table presents a summary of our future minimum payments under non-cancellable operating lease agreements and certain contractual service and licensing obligations as of June 30, 2013 (in thousands):

Years Ending December 31,	Operating Lease Obligations	Service and Licensing Obligations	Total Obligations
2013 (six months)	$ 1,787	$ 966	$ 2,753
2014	3,462	948	4,410
2015	2,274	138	2,412
2016	2,318	-	2,318
2017	2,385	-	2,385
Thereafter	5,040	-	5,040
Total	$ 17,266	$ 2,052	$ 19,318

Off-Balance Sheet Arrangements

We do not have any off-balance sheet arrangements, investments in special purpose entities or undisclosed borrowings or debt. Additionally, we are not a party to any derivative contracts or synthetic leases.

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ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our financial instruments that are exposed to concentrations of credit risk principally consist of cash and cash equivalents and accounts receivable. As of December 31, 2012 and June 30, 2013, our cash and cash equivalents were invested as follows (in thousands):

	December 31, 2012	June 30, 2013
Cash (1)	$ 27,484	$ 17,594
Money market funds (2)	113,365	72,119
Total cash and cash equivalents	$ 140,849	$ 89,713

(1) We deposit our cash and cash equivalents in accounts with major banks and financial institutions and such deposits are in excess of federally insured limits. We also have deposits with major banks in China that are denominated in both U.S. dollars and Chinese Renminbi and are not insured by the U.S. federal government.

(2) At December 31, 2012 and June 30, 2013 money market funds consisted of U.S. government-sponsored enterprise bonds and discount notes, U.S. government treasury bills and notes and repurchase agreements collateralized by U.S. government obligations.

We do not require collateral or other security for our accounts receivable. As of December 31, 2012, four customers represented 25%, 22%, 14% and 11%, respectively, for a combined total of 72% of our $4.5 million outstanding accounts receivable balance. As of June 30, 2013, one customer represented 68% of our $5.3 million outstanding accounts receivable balance. No other customers represented 10% or more of our total accounts receivable at December 31, 2012 and June 30, 2013. We believe the potential for collection issues with any of our customers is minimal as of June 30, 2013. Accordingly, our estimate for uncollectible amounts at June 30, 2013 was not material.

Significant Customers

Substantially all revenue for the three and six months ended June 30, 2012 and 2013 was generated from customers located in the United States. Carriers representing 10% or more of our total revenue in the three and six months ended June 30, 2012 and 2013 are presented in the table below:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2013	2012	2013
Humana	13%	17%	15%	20%
WellPoint (1)	15%	13%	13%	12%
UnitedHealthcare (2)	14%	11%	13%	11%

(1) Wellpoint includes other carriers owned by Wellpoint.
(2) UnitedHealthcare includes other carriers owned by UnitedHealthcare.

Foreign Currency Exchange Risk

To date, substantially all of our revenue has been derived from transactions denominated in United States Dollars. We have exposure to adverse changes in exchange rates associated with operating expenses of our foreign operations, which are denominated in Chinese Yuan Renminbi. Foreign currency fluctuations have not had a material impact historically on our results of operations; however, there can be no assurance that future fluctuations will not have material adverse effects on our results of operations. We have not engaged in any foreign currency hedging or other derivative transactions to date.

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ITEM 4. CONTROLS AND PROCEDURES

Evaluation of Our Disclosure Controls and Procedures

Our management, with the participation of our chief executive officer and chief financial officer, evaluated the effectiveness of our disclosure controls and procedures pursuant to Rules 13a-15(b) and 15d-15(b) under the Securities Exchange Act of 1934, as amended, as of the end of the period covered by this Quarterly Report on Form 10-Q.

Based on management's evaluation, our chief executive officer and chief financial officer concluded that our disclosure controls and procedures are effective to provide reasonable assurance that information we are required to disclose in reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in Securities and Exchange Commission rules and forms, and that such information is accumulated and communicated to our management, including our chief executive officer and chief financial officer, as appropriate, to allow timely decisions regarding required disclosure.

Changes in Internal Control Over Financial Reporting

There were no changes in our internal control over financial reporting that occurred during the three months ended June 30, 2013 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Inherent Limitations on Effectiveness of Controls

Our management, including our chief executive officer and chief financial officer, do not expect that our disclosure controls or our internal control over financial reporting will prevent all errors and all fraud. A control system, no matter how well conceived and operated, can provide only reasonable, not absolute, assurance that the objectives of the control system are met. Further, the design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that all control issues and instances of fraud, if any, have been detected. These inherent limitations include the realities that judgments in decision-making can be faulty, and that breakdowns can occur because of a simple error or mistake. Additionally, controls can be

circumvented by the individual acts of some persons, by collusion of two or more people or by management override of the controls. The design of any system of controls also is based in part upon certain assumptions about the likelihood of future events, and there can be no assurance that any design will succeed in achieving its stated goals under all potential future conditions; over time, controls may become inadequate because of changes in conditions, or the degree of compliance with policies or procedures may deteriorate. Because of the inherent limitations in a cost-effective control system, misstatements due to error or fraud may occur and not be detected.

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PART II

OTHER INFORMATION

ITEM 1. LEGAL PROCEEDINGS

In the ordinary course of our business, we have received and may continue to receive inquiries from state regulators relating to various matters. We also have become, and may in the future become, involved in litigation in the ordinary course of our business.

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ITEM 1A. RISK FACTORS

In addition to other information in this Quarterly Report on Form 10-Q and in other filings we make with the Securities and Exchange Commission, the following risk factors should be carefully considered in evaluating our business as they may have a significant impact on our business, operating results and financial condition. If any of the following risks actually occurs, our business, financial condition, results of operations and future prospects could be materially and adversely affected. Because of the following factors, as well as other variables affecting our operating results, past financial performance should not be considered as a reliable indicator of future performance and investors should not use historical trends to anticipate results or trends in future periods.

Risks Related to Our Business

Changes and developments in the health insurance system in the United States as a result of health care reform or otherwise could harm our business.

Our business depends upon the private sector of the United States health insurance system, its relative role in financing health care delivery and health insurance carriers' use of, and payment of commissions to, agents and brokers to market health insurance plans. In March 2010, the federal Patient Protection and Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act were signed into law. These health care reform laws contain provisions that have and will continue to change the industry in which we operate in substantial ways. Among several other provisions, they include a mandate requiring individuals to maintain health insurance or face tax penalties; a mandate that certain employers offer their employees group health insurance coverage or face tax penalties; requirements relating to employer contribution to employee health coverage; prohibitions against insurance companies using pre-existing health conditions as a reason to deny an application for health insurance; prohibitions on rescission of health insurance; prohibitions on lifetime coverage limits; requirements for guaranteed renewability of health insurance plans; health insurance premium setting guidelines; limitations on deductibles and cost-sharing; medical loss ratio requirements that require each health insurance carrier to spend a certain percentage of their premium revenue on reimbursement for clinical services and activities that improve health care quality and, if they do not, to provide rebates to policyholders; minimum benefit levels for health insurance plans, including limitations on annual coverage limits; taxes and assessments on health insurance carriers; establishment of state and/or federal health insurance exchanges to facilitate access to, and the purchase of, health insurance; open enrollment periods for individual and family health insurance; assistance for member run health insurance issuers; creation of multi-state health insurance plans to be offered on the exchanges and with oversight from the Office of Personnel Management; requirements for uniform disclosure relating to the costs and benefits of health insurance; government subsidized high risk pools; an expansion of Medicaid so that more individuals will be insured under state Medicaid programs; and subsidies and cost-sharing credits to make health insurance more affordable for those below certain income levels. Many aspects of health care reform do not go into effect until 2014, although certain provisions currently are effective, such as medical loss ratio requirements for individual and family and small business health insurance, a prohibition against insurance companies using pre-existing health conditions as a reason to deny the application of children for health insurance and a requirement that persons 26 years of age and younger be able to stay on a parent's health insurance plan. Health care reform legislation requires various departments of the executive branch to adopt

regulations implementing its provisions. In addition, state governments have adopted, and will continue to adopt, changes to their existing laws and regulations in light of federal health care reform legislation and regulations.

The implementation of health care reform could increase our competition; reduce or eliminate the need for health insurance agents or demand for the health insurance for individuals, families or small businesses that we sell; decrease the number of health insurance plans that we sell as well as the number of health insurance carriers offering them; change the benefits and/or premiums for the plans we sell; cause a substantial reduction in our membership; or cause health insurance carriers to reduce our commissions and other amounts they pay for our services or change our relationship with them in other ways, any of which could materially harm our business, operating results and financial condition. For instance, beginning in 2014 health insurance carriers offering coverage in the individual or small group health insurance market must ensure that such coverage meets certain actuarial value standards, includes certain minimum health benefits and is not subject to lifetime or, for most health insurance benefits, annual dollar amount coverage limits. Individuals are required to hold plans providing minimum essential coverage to meet the mandate for health insurance and avoid a tax penalty. It is unclear whether this tax penalty is sufficient enough to drive a substantial number of new entrants into the health insurance market, and if it does not, our business, operating results and financial condition could be harmed. Moreover, many of the individual and small group health insurance plans we have sold do not cover all of the minimum essential benefits or meet other standards under health care reform. We could suffer a substantial reduction in our membership as a result of our

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members moving to plans that contain minimum essential benefits under health care reform if we do not remain the agent of record on their plan. In addition, the existing plans of our members could be modified with an increase in the cost of the plan or terminated, which also could cause a reduction in our membership and materially harm our business, operating results and financial condition. Various aspects of health care reform also could cause health insurance carriers to determine to limit the type of health insurance plans we sell and the geographies in which we sell them, to exit the business of selling insurance plans in a particular jurisdiction, to eliminate certain categories of products or attempt to move members into new plans for which we receive lower or no commissions, any of which would materially harm our business, operating results and financial condition.

As a part of healthcare reform, each state is required to implement a health insurance exchange by October 2013 where individuals and small businesses can purchase health insurance. If a state does not implement a health insurance exchange, the federal government will implement and operate the exchange for that state. Among other things, the exchanges will have websites where individuals and small businesses can shop for and purchase health insurance, and they also will have offline customer support. The exchanges will be a new source of competition for us. In the event our existing members purchase health insurance directly through health insurance exchanges without using our services, we will no longer receive commission revenue as a result of our sale of health insurance to them, and exchanges will compete with us for new members. Competitive pressure from health insurance exchanges may result in our experiencing increased marketing costs, decreased traffic to our website and loss of market share, and may otherwise harm our business, operating results and financial condition. In addition, there have been recent proposals in certain states and by the federal government that health insurance carriers be required to offer agents and brokers the same commission rates for plans the health insurance carrier offers on state's health insurance exchange and outside of the health insurance exchange. It is unclear what impact adoption of laws and regulations like these will have on our business. However, if they result in a reduction in our commission rates, our business, operating results and financial condition would be harmed.

In addition to the expansion of Medicaid eligibility as a part of health care reform, individuals and families whose incomes are between 133% and 400% of the federal poverty level will generally be entitled beginning in 2014 to subsidies in connection with their purchase of health insurance. In order to be eligible for a subsidy, qualified individuals must purchase subsidy qualifying health plans through a government-run health insurance exchange. These qualified health plans are required to be purchased during an initial open enrollment period scheduled to begin in October 2013 and run through March 2014, and qualified individuals can thereafter change their qualified health plan only during annual enrollment periods scheduled to occur from October 15 through December 7 of each year thereafter, subject to states extending the period and exceptions for special enrollment periods for certain qualifying events. Some states and health insurance carriers have adopted, and others may adopt, open enrollment periods for the purchase of health insurance outside of government-run health insurance exchanges. It may be difficult for us to handle as a business any increased volume of health insurance transactions that would occur in a short period of time during the anticipated enrollment periods. Moreover, with respect to qualified health plans, state and/or the federal governments may not have implemented the ability for agents and brokers to submit health insurance applications for qualified health plans through them. In the aggregate, a shift to open enrollment periods of limited duration in the individual and family and small business health insurance markets may result in a reduction in our membership and revenue; increase in our expenses, particularly during certain periods of the year; and otherwise may harm our business, operating results and financial condition, particularly given that the open enrollment for qualified health plans and other health plans would overlap with the annual enrollment period for Medicare plans.

A federal regulation promulgated under the Patient Protection and Affordable Care Act has been issued that clarifies that states may, but are not required to, allow agents and brokers such as us to market the qualified health plans offered on government-run health insurance exchanges and that are the plans that subsidy-eligible individuals must purchase in order to receive their subsidies. While there are details that need to be clarified by the federal government, states and health insurance carriers, it is clear that, in order to offer qualified health plans, agents and brokers must meet certain conditions, such as entering into an agreement with the health insurance exchange, ensuring that the enrollment and subsidy application is completed through the state's health insurance exchange (or federally operated exchange in states without individual health insurance enrollment capability) and complying with privacy, security and other standards, some of which have been recently issued and contain requirements that are new to us. In the event Internet-based agents and brokers such as us use the Internet for plan selection purposes, their websites are required to meet certain additional conditions, such as compliance with standards for display of health plan and related information; providing consumers the ability to view all health plans offered on the government-run exchange; displaying certain health plan and other data available on the exchange; and providing a mechanism for consumers to withdraw from the application process on the agent or broker's website. A substantial number of our existing members may become eligible for subsidies in connection with their purchase of health insurance as a result of health care reform, and we may experience difficulty in satisfying the conditions and requirements to

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offer qualified health plans to them and others. Even if we are able to satisfy the conditions and requirements, we may not be able to do so in time for all or a portion of the initial or other enrollment periods. Moreover, we depend upon states (and in the case of the federally operated exchange, the federal government) to permit us to offer these plans and to have implemented the capability to receive enrollments from us. We also depend upon health insurance companies to allow us to sell qualified health plans and to pay us commissions in connection with their sale. In the event we are not successful in gaining the ability to sell individual and family qualified health insurance plans, or if health insurance carriers pay us no commissions or reduced commissions in connection with the sale of these plans, we could lose a substantial number of existing and potential members and commission revenue we receive as a result of the sale of individual and family and small business health insurance products, which would materially harm our business, operating results and financial condition. In part to attempt to satisfy conditions necessary for us to use our Internet technology platform to enroll individuals into qualified health plans as a health insurance agent, and assist individuals in applying for subsidies, through government-run health insurance exchanges, we have incurred increased operating expenses and expect to continue to do so. These past and expected increased operating expenses may not result in increased revenue for a number of reasons both within and outside of our control. If our revenues do not increase to offset these expected increases in costs and operating expenses, our financial condition and results of operations could be negatively affected.

We recently entered into an agreement with the Centers for Medicare and Medicaid Services, or CMS, relating to our ability to enroll individuals in qualified health plans through the federally operated exchange. The agreement relates to our gaining access to the federal government data hub that contains information necessary for determining the eligibility of individuals to purchase qualified health plans and to receive subsidies in connection with their purchase of health insurance. We must enter into additional agreement(s) with CMS to be authorized to enroll individuals in qualified health plans through the federally operated exchange. The agreement that we have entered into contains comprehensive privacy and security and other requirements that we must meet and implement. In order to be able to enroll individuals into qualified health plans, we also must satisfy several other regulatory requirements and comply with additional laws and regulations. There are risks and uncertainties relating to our ability to enroll individuals into qualified health plans through the federally operated exchange. Among other things, we must enter into additional agreement(s) and satisfy the requirements contained in the relevant agreements as well as applicable laws and regulations; complete development of a compliant web platform incorporating those requirements; obtain qualified health plan information from health insurance carriers and CMS and incorporate it into our web platform; implement a privacy and security program to conform to the privacy and security requirements of the our agreement with CMS as well as applicable laws and regulations; and successfully integrate with the federally operated exchange and the federal data hub so that information may be passed to and from us relating to qualified health plan and subsidy eligibility. We depend upon the federal government for a number of things relating to our ability to enroll individuals into qualified health plans through the federally operated exchange, including integration and certain qualified health plan information that is required under the applicable regulations to be displayed on our website. We cannot ensure that we will be able to enroll individuals into qualified health plans at the beginning of the initial enrollment period on October 1, 2013 or within any other specific timeframe. If we are not able to enroll individuals into qualified health plans in time for the initial enrollment period, our business, operating results and financial condition could be harmed.

The medical loss ratio requirements that are a part of health care reform have harmed and will continue to harm our business.

The federal Patient Protection and Affordable Care Act enacted in March 2010 and related amendments in the Health Care and Education Reconciliation Act of 2010 contain provisions requiring health insurance carriers to maintain specified medical loss ratios. The medical loss ratio requirements for both individual and family and small business health insurance are effective for calendar year 2011 and later years and, among other things, require health insurance companies to spend 80% of their premium revenue in each of their individual and small group businesses on reimbursement for clinical services and activities that improve health care quality. The medical loss ratio requirement for Medicare Advantage plans is 85% and goes into effect in 2014. If a health insurance carrier fails to meet medical loss ratio requirements, the health insurance carrier is required to rebate a portion of its premium revenue to its members to make up for the difference.

Carrier reaction to the individual and family medical loss ratio requirements has been to significantly reduce the commissions we receive in connection with the sale of these plans. These commission rate reductions have and will continue to significantly impact our business and operating results. Health insurance carriers may determine to reduce or further reduce our individual and family and small group commissions, and may reduce our Medicare Advantage plan commissions for the sale of plans with effective dates in 2014, as a result of the medical loss ratio requirements or other aspects of health care reform, which would harm our business, operating results and financial condition. In addition, if

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health insurance companies fail to meet medical loss ratio requirements, we may be required to pay back commissions that are related to any premium amounts the carriers are required to rebate policy holders as a result, which would harm our business, operating results and financial condition. The medical loss ratio requirements also may cause certain health insurance carriers to limit the geographies in which they sell health insurance or exit certain markets altogether, place less reliance on agents to distribute their plans, or limit their health insurance offerings in any number of other ways, each of which would harm our business, operating results and financial condition. The implementation of medical loss ratio requirements has caused and could further cause health insurance carriers to reduce the amount they are willing to spend in connection with our sponsorship and advertising and technology licensing businesses, which also could harm our business, operating results and financial condition.

Our business may be harmed if we lose our relationship with health insurance carriers or our relationship with health insurance carriers is modified.

We typically enter into contractual agency relationships with health insurance carriers that are non-exclusive and terminable on short notice by either party for any reason. In many cases, health insurance carriers also may amend the terms of our agreements unilaterally on short notice. Carriers may be unwilling to allow us to sell their existing or new health insurance plans, or desire to amend our agreements with them, for a variety of reasons, including for competitive or regulatory reasons, or because they do not want to be associated with our brand. In addition, many aspects of health care reform are scheduled to be implemented in 2014, which may cause carriers to modify their relationship with us given the substantial changes in the industry in which we operate. For instance, in addition to the medical loss ratio requirements, health care reform contains taxes and assessments on health insurance carriers that may make their businesses less profitable. In the future, and as a result of health care reform or for other reasons, an increasing number of health insurance carriers may decide to reduce our commissions, rely on their own internal distribution channels, including traditional in-house agents and carrier websites, to sell their own plans and, in turn, could limit or prohibit us from selling their plans on our ecommerce platform. For instance, carriers may choose to exclude us from their most profitable or popular plans or may determine not to distribute insurance plans in the individual and family and small business markets in certain geographies or altogether. The termination or amendment of our relationship with a carrier could reduce the variety of health insurance plans we offer, which could harm our business, operating results and financial condition. It also could adversely impact, or cause the termination of, commissions for future sales and for past sales, which would materially harm our business, operating results and financial condition. Our business could also be harmed if in the future we fail to develop new carrier relationships and are unable to offer consumers a variety of health insurance plans in each jurisdiction.

The health insurance industry in the United States has experienced a substantial amount of consolidation over the past several years, resulting in a decrease in the number of health insurance carriers. In the future, we may be forced to offer insurance policies from a reduced number of insurance carriers or to derive a greater portion of our revenue from a more concentrated number of carriers as our business and the health insurance industry evolve. We derived 15% and 20% of our total revenue in the six months ended June 30, 2012 and 2013, respectively, from Humana. We derived 13% and 12% of our total revenue in the six months ended June 30, 2012 and 2013, respectively, from carriers owned by Wellpoint. We derived 13% and 11% of our total revenue in the six months ended June 30, 2012 and 2013, respectively, from carriers owned by UnitedHealthcare. We have several agreements that govern our sale of health

insurance plans with these health insurance carriers. They may be unilaterally amended or terminated by the carrier on short notice and the amendment or termination could adversely impact or cause the termination of the commission payments that we receive from these health insurance carriers, which would harm our business, operating results and financial condition. Notwithstanding our separate agreements with various carriers directly or indirectly owned by the same entity, certain carriers have attempted and may continue to attempt to consolidate our relationship with them, which could increase the impact of carrier concentration on us, decrease the commission rates we receive and adversely affect our financial results, particularly in states where we offer health insurance from a relatively smaller number of carriers or where a small number of carriers dominates the market. The termination, amendment or consolidation of our relationship with these and other health insurance carriers could materially harm our business, operating results and financial condition.

Our revenues and earnings may decline.

In 2011, we experienced a significant reduction in the commission rates that health insurance carriers pay us on the individual and family health insurance plans that we sell, primarily as a result of health care reform. We also have in the past and may in the future continue to make significant expenditures related to the development of our business, including expenditures relating to marketing, website technology development and the development of our business selling Medicare-related health insurance plans. Our ability to grow revenue and earnings will depend on a number of factors, including the

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success of our Medicare plan marketing and sales business, our ability to attract individuals, families and small businesses to purchase health insurance through our ecommerce platform, our maintaining our relationships with health insurance carriers and the commission rates we receive for our sale of health insurance plans and our ability to maintain our relationship with existing members within historical levels. If we are not successful in these areas, our business, operating results and financial condition will be harmed.

Our revenue will be adversely impacted if our membership does not grow. The individual and family commission rates that we receive are typically higher in the first twelve months of a policy. After the first twelve months, they generally decline significantly. The Medicare-related commission rates that we receive may be higher in the first twelve months of a policy if the policy is the first Medicare-related policy issued to the member. Accordingly, to the extent that our net addition of new members slows or we experience a reduction in the number of our members, our revenue would be adversely impacted due to a decline in commissions we receive for members whose policies have been active for more than twelve months in addition to the reduction in revenue growth that would occur solely as a result of a decline in our membership. The commission rates we receive are impacted by a variety of other factors, including the particular health insurance plans chosen by our members, the carriers offering those plans, our members' states of residence, the laws and regulations in those jurisdictions and health care reform. Our commission rate per member has, and could in the future, decrease as a result of either reductions in contractual commission rates or unfavorable changes in health insurance carrier override commission programs, each of which are beyond our control and may occur on short notice. To the extent these and other factors cause our commission rate per member to decline, our rate of revenue growth may decline and our business, operating results and financial condition would be harmed.

We may not be successful in our efforts to market and sell Medicare-related health insurance plans as a health insurance agent.

In 2010 we began to actively market the availability of Medicare-related health insurance plans using our ecommerce platforms, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. We refer to these plans as Medicare plans. We market Medicare plans to Medicare-eligible individuals, who are predominately senior citizens over the age of 65. The sale of Medicare Advantage and Medicare Part D prescription drug plans are subject to an annual enrollment period during the fourth quarter of each year, when a substantial percentage of the annual sales of these plans occur. We sell Medicare plans as a health insurance agent using our websites and customer care centers.

Our Medicare plan related revenue is concentrated in a small number of health insurance carriers. The success of our entry into the market for Medicare plans as a health insurance agent will depend upon our ability to enter into new and maintain existing relationships with health insurance carriers on favorable economic terms. The limited number of our Medicare plan carrier relationships makes us vulnerable to changes in carrier commission rates and the competitiveness of our carrier partners Medicare products. If our Medicare carrier partners reduce our commission rates, reduce the amount they pay us for advertising services, or the competitiveness of their products declines compared to original Medicare or the products of Medicare carriers with which we do not have a relationship, our

business, operating results and financial condition would be harmed. In addition, we may temporarily or permanently lose the ability to market and sell Medicare plans for our Medicare plan carrier partners. For instance, a carrier may terminate our relationship. Moreover, the Centers for Medicare and Medicaid Services, or CMS, has and will continue to penalize health insurance carriers for certain regulatory violations by not allowing them to market and sell Medicare plans for significant periods of time. Given the small number of our Medicare carrier relationships, if we lose a relationship with a health insurance carrier to market their Medicare plans temporarily or permanently for this or any other reason, our sales as a health insurance agent and Medicare plan related revenue could suffer significantly, and our business, operating results and financial condition would be harmed. The agreements that we have with health insurance carriers to sell Medicare plans may be unilaterally amended or terminated by the carrier on short notice and the amendment or termination could adversely impact, or cause the termination of, the commission payments that we receive for selling their Medicare plans, which would harm our business operating results and financial condition.

CMS must approve our websites and call center scripts for us to be able to generate Medicare plan demand and sell Medicare plans to Medicare-eligible individuals as a health insurance agent. Moreover, we use Medicare plan cost and benefit data collected and made publicly available by CMS. In the event that CMS disapproves, or delays approval, of our websites or call center scripts, or does not timely release Medicare plan cost and benefit data for the following year’s Medicare plans prior to the annual enrollment period, we could lose a significant source of Medicare plan demand and our ability to sell Medicare plans would be adversely impacted, each of which would harm our business, operating results and financial condition.

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Our success in expanding into the Medicare plan market as a health insurance agent will also depend upon a number of additional factors, including:

- our ability to continue to adapt our ecommerce platform to market Medicare plans, including our development or acquisition of marketing tools and features important in the sale of Medicare plans online and the modification of our existing user experience for new plans targeted at a different demographic;

- our success in marketing our ecommerce platform to Medicare-eligible individuals and in entering into business development relationships to drive Medicare-eligible individuals to our ecommerce platform;

- our effectiveness in entering into and maintaining relationships with marketing partners, including existing pharmacy chain partners that refer Medicare-eligible individuals to us;

- our ability to hire and retain additional employees with experience in Medicare, including our ability to timely implement Medicare sales expertise into our customer care centers;

- our ability to implement and maintain an effective information technology infrastructure for the sale of Medicare plans, including the infrastructure and systems that support our websites, call centers and call recording;

- our ability to comply with the numerous, complex and changing laws and regulations and CMS guidelines relating to the marketing and sale of Medicare plans, including continuing to conform our online and offline sales processes to those laws and regulations; and

- the effectiveness with which our competitors market the availability of Medicare plans from sources other than our ecommerce platform.

As a result of these factors, we may prove unsuccessful in marketing Medicare plans and acting as a health insurance agent in connection with their sale, which would harm our business, operating results and financial condition. In addition, if our efforts to market Medicare plans during any annual enrollment period were impeded due to lack of health insurance carrier or CMS approval, or for other reasons, the impact on our business, operating results and financial condition would be significantly greater given the seasonality of our Medicare-related revenues, membership acquisition and expenses and the fact that much of the sales of Medicare plans occur during this period.

Our ability to sell Medicare-related health insurance plans as a health insurance agent depends on our ability to timely hire, train and retain licensed health insurance agents for our customer care center operations and our ability to maintain information technology systems to facilitate their sale of Medicare plans.

In addition to our websites, we rely upon our customer care centers to sell Medicare plans. The success of our customer care center operations is largely dependent on licensed health insurance agents and other employees. In order to sell Medicare-related health insurance plans, our health insurance agent employees must first be licensed by the states in which they are selling plans and certified and appointed with the health insurance carrier that offers the plans in each state that the Medicare-related health insurance product is being sold by the agent. Because the majority of Medicare plans are sold in the fourth quarter each year during the Medicare annual enrollment period, we are required to hire and train a significant number of additional employees on a temporary or seasonal basis in a limited period of time. We must also ensure that our health insurance agent employees are timely licensed in a significant number of states and certified and appointed with the health insurance carriers whose products we sell. We depend upon state departments of insurance and health insurance carriers for their licensing, certification and appointment of our health insurance agent employees. We may not be successful in timely hiring a sufficient number of additional licensed agents or other employees for the Medicare annual enrollment period, and even if we are successful, these employees may experience delays in obtaining health insurance licenses and certifications and health insurance carrier appointments with our health insurance carrier partners. If we and our health insurance agent employees are not successful in these regards, our ability to sell Medicare-related health insurance plans will be impaired during the annual enrollment period, which would harm our business, operating results and financial condition.

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The success of our Medicare plan customer care center operations also is dependent on information technology systems. The vast majority of our Medicare plan members utilize our customer care center in connection with their purchase of a Medicare plan. CMS rules require that our health insurance agent employees utilize CMS-approved scripts in connection with the sale of Medicare plans and that we record and maintain the recording of telephonic interactions relating to the sale of Medicare plans. We rely on telephone, call recording and customer relationship management systems in our Medicare customer care center operations related to these and other functions, and we are dependent on third parties for some of them, including our telephone and call recording systems. The effectiveness and stability of our Medicare customer care center systems are critical to our ability to sell Medicare plans, particularly during the Medicare annual enrollment period, and the failure or interruption of any of these systems or any inability to handle increased volume during the annual enrollment period would harm our business, operating results and financial condition.

Factors beyond our control may negatively impact our ability to market and sell Medicare plans.

We determined to enter into the Medicare plan market because we believe the number of individuals becoming eligible for Medicare is increasing and these individuals are increasingly using the Internet to shop for health insurance plans. We also believe that, on average, member retention rates and the commissions that health insurance carriers pay in connection with the sale of Medicare plans compare favorably to the member retention rates and commissions we receive in connection with our sale of individual and family health insurance. Should we prove to be wrong, or should these circumstances reverse, our success in marketing Medicare plans would be materially and adversely impacted, which could harm our business, operating results and financial condition. For instance, portions of health care reform impose significant changes to original Medicare and the Medicare Advantage program by, among other things, increasing the benefits original Medicare provides, reducing payments to Medicare Advantage plans and imposing medical loss ratio requirements for Medicare Advantage plans. In addition, CMS may also determine to reduce the payments it makes to health insurance carriers in connection with the sale of Medicare Advantage plans. In the event health care reform, the actions of the federal government or other circumstances decrease the demand for Medicare Advantage plans or other alternatives to original Medicare, or result in a reduction in the amount paid to us in connection with the sale of these plans, our business operating results and financial condition could be harmed.

The marketing and sale of Medicare plans are subject to numerous, complex and frequently changing laws and regulations, and any noncompliance with them could harm our business, operating results and financial condition.

The marketing and sale of Medicare plans are subject to numerous laws, regulations and guidelines at the federal and state level. The marketing and sale of Medicare Advantage and Medicare Part D prescription drug plans are principally regulated by CMS. The marketing and sale of Medicare Supplement plans are principally regulated on a state-by-state basis by state departments of insurance. The laws and regulations applicable to the marketing and sale of Medicare plans are numerous, ambiguous and complex, and, particularly with respect to regulations and guidance issued by CMS for Medicare Advantage and Medicare Part D prescription drug plans, change frequently. As a result

of these laws, regulations and guidelines, we have altered, and likely will have to continue to alter, our websites and sales process to comply with several requirements that are not applicable to our sale of non-Medicare-related health insurance plans. For instance, many aspects of our online platforms and our marketing material and processes, as well as changes to these platforms, materials and processes, including call center scripts, must be approved on a regular basis by CMS and by health insurance carriers in light of CMS requirements. In addition, certain aspects of our Medicare plan marketing partner relationships with pharmacy chains have been in the past, and will be in the future, subjected to CMS and health insurance carrier review. Changes to the laws, regulations and guidelines relating to Medicare plans, their interpretation or the manner in which they are enforced could be incompatible with these relationships, our platforms or our sale of Medicare plans. Due to changes in CMS guidance or enforcement or interpretation of existing guidance, or as a result of new laws, regulations and guidelines, CMS, state departments of insurance or health insurance carriers may determine to object to or not to approve aspects of our online platforms or marketing material and processes and may determine that certain existing aspects of our Medicare-related business are not in compliance. As a result, the progress of our Medicare operations could be slowed or we could be prevented from operating aspects of our Medicare revenue generating activities altogether, which would harm our business, operating results and financial condition, particularly if it occurred during the Medicare annual enrollment period. It could also result in the write-down of the value of goodwill and intangible assets acquired in our PlanPrescriber acquisition.

The impact that health care reform legislation will have on the market for Medicare plans is unclear, but it could change demand for Medicare plans, the way these plans are delivered, the commissions that carriers pay to health insurance agents in connection with their sale or could adversely impact us in other ways. In the event that laws and regulations adversely impact our ability to market the availability of any type of Medicare plan on our ecommerce platform, or the amounts that

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health insurance agents are paid for selling these plans, our business, operating results and financial condition would be harmed.

Our future operating results are likely to fluctuate and could fall short of expectations.

Our operating results are likely to fluctuate as a result of a variety of factors, including the factors described elsewhere in this Risk Factors section, many of which are outside of our control. As a result, comparing our operating results on a period-to-period basis may not be meaningful and you should not rely on our past results as an indication of our future performance, particularly in light of the fact that our business and industry are undergoing substantial change as a result of health care reform. If our revenue or operating results fall below the expectations of investors or securities analysts, the price of our common stock could decline substantially.

Our business model is characterized primarily by revenue based on commissions we receive from insurance carriers whose policies are purchased by our members. We receive commissions and record related revenue for an individual and family, small business, ancillary or Medicare Supplement health insurance policy, typically on a monthly basis, until the health insurance policy is cancelled or we otherwise do not remain the agent on the policy. For both Medicare Advantage and Medicare Part D prescription drug plans, we record commission revenue on an annual basis but may receive commission payments from insurance carriers on either a monthly or annual basis typically for a period of up to six years, or longer depending on the carrier arrangement, provided that the policy remains active with us and we remain the agent on the policy.

A significant component of our marketing and advertising expenses consists of expenses incurred in search engine advertising at the time a consumer clicks on an advertisement and payments owed to our marketing partners in connection with applications submitted on our ecommerce platform by potential members referred to us by our marketing partners. As a result of this timing difference between expense and associated revenue recognition, our operating results and cash flows may be adversely affected in periods where we experience a significant increase in new applicants, which could occur in connection with the implementation of health care reform. The implementation of healthcare reform could cause a substantial number of our existing members to apply for new health insurance products and for us to receive a substantial number of health insurance applications from new members, which could cause us to incur a substantial amount of marketing and advertising expense over a limited period of time and harm our business, operating results and financial condition. In addition, if we incur other unanticipated or one-time expenses in a particular quarter, lose a significant amount of our member base for any reason or our commission rates are reduced, we would likely be unable to offset these expenses by increasing sales within that quarter or to replace lost revenue in the quarter with revenue from new members. As a result, our quarterly results may suffer due to unanticipated expenses, one-time charges or significant member turnover.

Current economic conditions and other factors beyond our control may negatively impact our business, operating results and financial condition.

Our revenue depends upon demand for health insurance in the individual and family and small business markets, which can be influenced by a variety of factors beyond our control. For instance, an increased number of individuals have become self-employed or unemployed. In addition, as a result of substantial health insurance premium inflation in recent years, we believe that many employers have sought to reduce the costs associated with providing health insurance to their employees, including offering fewer benefits to employees, reducing or eliminating dependent coverage, increasing employee health insurance premium contributions and eliminating health insurance benefits altogether. We have no control over the economic and other factors that influence these trends, and they may reverse, including as a result of health care reform legislation. If economic or other factors beyond our control negatively impact our business, our business, operating results and financial condition could be harmed.

We believe that demand for the health insurance and services we offer are impacted by prevailing economic conditions. We cannot be certain of the future impact that the recent recession and other economic conditions will have on our business. A further softening of demand for health insurance and services offered by us, whether caused by changes in customer preferences or a weak U.S. economy, including as a result of disruptions in the global financial markets or a decrease in general consumer confidence, could adversely impact our operating results. Consumers may attempt to reduce expenses by cancelling existing health insurance purchased through us, determine not to purchase new health insurance through us, or purchase health insurance plans with lower premiums for which we receive lower commissions. To the extent the economy or other factors adversely impact our membership retention or the number or type of health insurance applications submitted through us and that are approved by health insurance carriers, our rate of growth will decline and our business and operating

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results will be harmed. A continuing negative economic environment could also adversely impact the health insurance carriers whose plans are offered on our ecommerce platform, and they may determine to reduce their commission rates, change their underwriting practices (prior to the implementation of the guaranteed issue aspect of health care reform) so that fewer health insurance applications are approved or take other actions that would negatively impact our sale of health insurance as well as our sponsorship and technology licensing businesses.

If we are not successful in cost-effectively converting visitors to our website and customer call centers into members, our business and operating results would be harmed.

Our growth depends in large part upon growth in our membership. The rate at which consumers visiting our ecommerce platform and customer call centers seeking to purchase health insurance are converted into members is a significant factor in the growth of our membership. A number of factors have influenced, and could in the future influence, the conversion rate for any given period, some of which are outside of our control. These factors include:

- changes in consumer shopping behavior due to circumstances outside of our control, such as economic conditions, consumers' ability or willingness to pay for health insurance, availability of unemployment benefits or proposed or enacted legislative or regulatory changes impacting our business;

- the quality of and changes to the consumer experience on our ecommerce platform or with our customer care center;

- regulatory requirements, including those that make the experience on our online platforms cumbersome or difficult to navigate;

- the variety, competitiveness and affordability of the health insurance plans that we offer;

- system failures or interruptions in the operation of our ecommerce platform or call center operations;

- changes in the mix of consumers who are referred to us through our direct, marketing partner and online advertising member acquisition channels;

- the health insurance carriers offering the health insurance plans for which consumers have expressed interest, and the degree to which our technology is integrated with those carriers;

- health insurance carrier underwriting practices (prior to the implementation of the guaranteed issue aspect of health care reform) and guidelines applicable to applications submitted by consumers and the amount of time a carrier takes to make a decision on that application; and

- competitive offerings.

Our conversion rates can be impacted by changes in the mix of consumers referred to us through our member acquisition channels. For example, our conversion rates have historically been lower with respect to consumers referred to us by Internet lead aggregators and relatively higher with respect to consumers coming to us through our direct member acquisition channel. In addition, we may make changes to our ecommerce platform or undertake other initiatives in an attempt to improve consumer experience or for other reasons. These changes in the past, and may in the future, have the unintended consequence of adversely impacting our conversion rates. A decline in the percentage of consumers who submit health insurance applications on our ecommerce platform or telephonically via our customer call centers and are converted into members could cause an increase in our cost of acquiring members on a per member basis. To the extent the rate at which we convert consumers visiting our ecommerce platform or telephonically via our customer call centers into members suffers, our membership growth rate may decline, which would harm our business, operating results and financial condition.

If we are unable to retain our members, our business and operating results would be harmed.

We receive revenue from commissions health insurance carriers pay to us for health insurance policies sold through our ecommerce platform. When one of these policies is cancelled, or if we otherwise do not remain the agent on the policy, we no longer receive the related commission revenue. Individuals, families and small businesses may choose to discontinue

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their health insurance policies for a variety of reasons. For example, individuals and families may replace a health insurance policy purchased through us with a health insurance policy provided by a new or existing employer or may determine that they can no longer afford health insurance. In addition, our members may choose to purchase new policies using a different agent if, for example, they are not satisfied with our customer service or the health insurance plans that we offer. Consumers may also purchase health insurance policies from government-run health insurance exchanges after their implementation as a result of health care reform. Health insurance carriers may also terminate health insurance plans purchased and held by our members. If we are not successful in transferring members covered under a terminated plan to another policy that we offer, we will lose these members and associated commission revenue. Our cost of acquiring a new member is substantially greater than the cost involved in maintaining our relationship with an existing member. If we are not able to successfully retain existing members and limit member turnover, our revenue and operating margins will be adversely impacted and our business, operating results and financial condition would be harmed.

Changes in the quality and affordability of the health insurance plans that carriers offer on our ecommerce platform could harm our business and operating results.

The demand for health insurance marketed through our ecommerce platform is impacted by, among other things, the variety, quality and price of the health insurance plans we offer. Some health insurance carriers have announced their intention to exit certain state insurance markets where we have historically represented their insurance plans. If health insurance carriers do not continue to allow us to sell a variety of high-quality, affordable health insurance plans in the individual and family, small business, ancillary and Medicare markets, or if their offerings are limited or terminated as a result of consolidation in the health insurance industry, health care reform legislation or otherwise, our sales may decrease and our business, operating results and financial condition could be harmed.

Health insurance carriers could determine to reduce the commissions paid to us or change their underwriting practices in ways that reduce the number of insurance policies sold through our ecommerce platform, which could harm our business and operating results.

Our commission rates, and the commission override payments we receive from health insurance carriers for achieving sales volume thresholds or other objectives, are either set by each carrier or negotiated between us and each carrier. Carriers have altered, and may in the future alter, the contractual relationships we have with them on short notice, either by renegotiation or unilateral action. If these contractual changes result in reduced commissions, our business may suffer and our operating results and financial condition would be harmed. In addition, carriers periodically change the criteria they use for determining whether they are willing to insure individuals as well as other underwriting practices. At various times, carriers have applied more stringent underwriting criteria and practices to applications for health insurance. These practices result in a decrease in the rate at which insurance applications submitted through our ecommerce platform are approved. Changes in carrier underwriting criteria or practices (prior to the implementation of the guaranteed issue aspect of health care reform) could negatively impact sales of insurance policies on our ecommerce platform and could harm our business, operating results and financial condition.

If we are not able to maintain and enhance our brand, our business and operating results will be harmed.

We believe that maintaining and enhancing our brand identity is critical to our relationships with existing members, marketing partners and health insurance carriers and to our ability to attract new members, marketing partners and health insurance carriers. The promotion of our brand in these and other ways may require us to make substantial investments and we anticipate that, as our market becomes increasingly competitive, these branding initiatives may become increasingly difficult and expensive. Our brand promotion activities may not be successful or yield increased revenue, and to the extent that these activities yield increased revenue, the increased revenue may not offset the expenses we incur and our operating results could be harmed. If we do not successfully maintain and enhance our brand, our business may not grow and we could lose our relationships with health insurance carriers, marketing partners and/or members, which would harm our business, operating results and financial condition.

In addition, we have historically received media attention in connection with our public relations efforts. While we cannot be certain of the impact of media coverage on our business, if it were to be reduced, the number of consumers visiting our platform or customer call centers could decrease, and our cost of acquiring members could increase as a result of a reduction in the number of members coming from our direct member acquisition channel, both of which could harm our business, operating results and financial condition.

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System failures or capacity constraints could harm our business and operating results.

The performance, reliability and availability of our ecommerce platforms and underlying network infrastructures are critical to our financial results, our brand and our relationship with members, marketing partners and health insurance carriers. Although we regularly attempt to enhance our ecommerce platform and system infrastructure, system failures and interruptions may occur if we are unsuccessful in these efforts, if we are unable to accurately project the rate or timing of increases in our website traffic or for other reasons, some of which are completely outside our control. Although we have experienced only minor system failures and interruptions to date, we could experience significant failures and interruptions in the future, which would harm our business, operating results and financial condition.

We rely in part upon third-party vendors, including data center and bandwidth providers, to operate our ecommerce platforms. We cannot predict whether additional network capacity will be available from these vendors as we need it, and our network or our suppliers' networks might be unable to achieve or maintain a sufficiently high capacity of data transmission to allow us to process health insurance applications in a timely manner or effectively download data, especially if our website traffic increases. Any system failure that causes an interruption in or decreases the responsiveness of our services would impair our revenue-generating capabilities and harm our business and operating results and damage our reputation. In addition, any loss of data could result in loss of customers and subject us to potential liability. Our database and systems are vulnerable to damage or interruption from human error, earthquakes, fire, floods, power loss, telecommunications failures, physical or electronic break-ins, computer viruses, acts of terrorism, other attempts to harm our systems and similar events. In addition, our operations are vulnerable to earthquakes in the San Francisco Bay Area and elsewhere in Northern California.

Consumers may access our customer care centers for assistance in connection with submitting health insurance applications. We depend upon third parties, including telephone service providers and third party software providers, to operate our customer care centers. Any failure of the systems that we rely upon in the operation of our customer care center could negatively impact sales as well as our relationship with consumers and members, which could harm our business, operating results and financial condition.

If consumers or carriers opt for more traditional or alternative channels for the purchase and sale of health insurance, our business will be harmed.

Our success depends in part upon widespread consumer and health insurance carrier acceptance of the Internet as a marketplace for the purchase and sale of health insurance. Consumers and health insurance carriers may choose to depend more on traditional sources, such as individual agents, or alternative sources may develop, including as a result of health care reform legislation. Our future growth, if any, will depend in part upon:

- the growth of the Internet as a commerce medium generally, and as a market for consumer financial plans and services specifically;

- consumers' willingness to conduct their own health insurance research;

- our ability to make the process of purchasing health insurance online an attractive alternative to traditional and new means of purchasing health insurance;

- our ability to successfully and cost-effectively market our services as superior to traditional or alternative sources for health insurance to a sufficiently large number of consumers; and

- health insurance carriers' willingness to use us and the Internet as a distribution channel for health insurance plans.

If consumers and health insurance carriers determine that other sources for health insurance and health insurance applications are superior, our business will not grow and our operating results and financial condition would be harmed.

We depend upon Internet search engines to attract a significant portion of the consumers who visit our website, and if we are unable to effectively advertise on search engines on a cost-effective basis, our business and operating results would be harmed.

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We derive a significant portion of our website traffic from consumers who search for health insurance through Internet search engines, such as Google, Bing and Yahoo!. A critical factor in attracting consumers to our website is whether we are prominently displayed in response to an Internet search relating to health insurance. Search engines typically provide two types of search results, algorithmic listings and paid advertisements. We rely on both algorithmic listings and paid advertisements to attract consumers to our websites.

Algorithmic search result listings are determined and displayed in accordance with a set of formulas or algorithms developed by the particular Internet search engine. The algorithms determine the order of the listing of results in response to the consumer's Internet search. From time to time, search engines revise these algorithms. In some instances, these modifications have caused our website to be listed less prominently in algorithmic search results, which has resulted in decreased traffic to our website. We may also be listed less prominently as a result of new websites or changes to existing websites that result in these websites receiving higher algorithmic rankings with the search engine. Our website may become listed less prominently in algorithmic search results for other reasons, such as search engine technical difficulties, search engine technical changes and changes we make to our website. In addition, search engines have deemed the practices of some companies to be inconsistent with search engine guidelines and decided not to list their website in search result listings at all. If we are listed less prominently in, or removed altogether from, search result listings for any reason, the traffic to our websites would decline and we may not be able to replace this traffic, which in turn would harm our operating results. If we decide to attempt to replace this traffic, we may be required to increase our marketing expenditures, which would also increase our cost of member acquisition and harm our operating results.

We purchase paid advertisements on search engines in order to attract consumers to our website. We typically pay a search engine for prominent placement of our name and website when particular health insurance-related terms are searched for on the search engine, regardless of the algorithmic search result listings. In some circumstances, the prominence of the placement of our advertisement is determined by a combination of factors, including the amount we are willing to pay and algorithms designed to determine the relevance of our paid advertisement to a particular search term. As with algorithmic search result listings, search engines may revise the algorithms relevant to paid advertisements and websites other than our ecommerce platform may become more optimized for the algorithms. These changes may result in our having to pay increased amounts to maintain our paid advertisement placement in response to a particular search term. We could also have to pay increased amounts should the market share of major search engines continue to become more concentrated with a single search engine. Additionally, we bid against our competitors and others for the display of these paid search engine advertisements. Many of our competitors, including many health insurance carriers, have greater resources with which to bid and better brand recognition than we do. We have experienced increased competition from health insurance carriers and some of our marketing partners for both algorithmic search result listings and for paid advertisements, which has increased our marketing and advertising expenses. If this competition increases further, or if the fees associated with paid search advertisements increase as a result of algorithm changes or other factors, our advertising expenses could rise significantly or we could reduce or discontinue our paid search advertisements, either of which could harm our business, operating results and financial condition.

We rely significantly on marketing partners and our business and operating results would be harmed if we are unable to maintain effective relationships with our existing marketing partners or if we do not establish successful relationships with new marketing partners.

In addition to marketing through Internet search engines, we frequently enter into contractual marketing relationships with other online and offline businesses that promote us to their customers. These marketing partners include financial and online service companies, affiliate programs and online advertisers and content providers. We also have relationships with marketing partners, including pharmacy chains, that promote our Medicare platforms to their customers. We compensate many of our marketing partners for their referrals on a submitted health insurance application basis and, if they are licensed to sell health insurance, may share a percentage of the commission we earn from the health insurance carrier for each member referred by the marketing partner.

Many factors influence the success of our relationship with our marketing partners, including:

· the continued positive market presence, reputation and growth of the marketing partner;

· the effectiveness of the marketing partner in marketing our website and services, including whether the marketing partner is successful in maintaining the prominence of its website in algorithmic search result listings and paid Internet advertisements;

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- the compliance of our marketing partners, and of the manner marketing partners refer consumers to our platforms, with applicable laws, regulations and guidelines;

- the interest of the marketing partner's customers in the health insurance plans that we offer on our ecommerce platform;

- the contractual terms we negotiate with the marketing partner, including the marketing fees we agree to pay a marketing partner;

- the percentage of the marketing partner's customers that submit applications or purchase health insurance policies through our ecommerce platform;

- the ability of a marketing partner to maintain efficient and uninterrupted operation of its website; and

- our ability to work with the marketing partner to implement website changes, launch marketing campaigns and pursue other initiatives necessary to maintain positive consumer experiences and acceptable traffic volumes.

For instance, we partner with Internet lead aggregators who refer a significant number of consumers to our online platforms. Major search engines have in the past and may in the future determine not to list lead aggregator websites prominently in search result listings for various reasons, which would cause a significant reduction in the number of consumers referred to us through our marketing partner channel. If we are unable to maintain successful relationships with our existing marketing partners or fail to establish successful relationships with new marketing partners, our business, operating results and financial condition will be harmed.

The impact that health care reform will have on our relationships with marketing partners is unclear. To the extent that health care reform makes it less profitable or desirable for marketing partners to promote us to their customers, we may lose relationships with existing marketing partners and may have difficulty entering into relationships with new marketing partners. We may also need to reduce the compensation that we pay to marketing partners to the extent that health care reform has the effect of reducing commissions for individual and family health insurance. There is no guarantee that we will be able to amend our agreements to reduce the compensation that we pay to acceptable levels in light of the commission rates that we receive. If we are not able to do so, our business, operating results and financial condition could be harmed. In addition, the promulgation of laws, regulations or guidelines, or the interpretation of existing laws, regulations and guidelines, by state departments of insurance or by CMS, could cause our relationships with our marketing partners to be in noncompliance with those laws, regulations and guidelines. For instance, as a result of our acquisition of PlanPrescriber, we have marketing partner relationships with pharmacy chains that utilize aspects of our platform and tools. Our relationships with these pharmacy chains result in the referral of a significant number of individuals to us who are interested in purchasing Medicare plans. If CMS or state departments of

insurance were to change existing laws, regulations or guidelines, or interpret existing laws, regulations or guidelines, to prohibit these arrangements, we would experience a significant decline in the number of Medicare-eligible individuals who are referred to our platforms and customer care centers, which would harm our business, operating results and financial condition and could result in a write-down of the value of intangible assets acquired in our PlanPrescriber acquisition.

We rely on health insurance carriers to accurately and regularly prepare commission reports, and if these reports are inaccurate or not sent to us in a timely manner, our business and operating results could be harmed. We also may not recognize trends in our membership as a result of a lack of information from health insurance carriers.

For individual and family, small business, ancillary and Medicare Supplement health insurance plans, health insurance carriers typically pay us a specified percentage of the premium amount on a health insurance policy that we have sold during the period that a member maintains coverage under the policy. For both Medicare Advantage and Medicare Part D prescription drug policies, health insurance carriers typically pay us a fixed commission amount during the period the policy remains active, typically for up to six years, or longer depending on carrier the arrangement, provided that the policy remains active with us. We rely on health insurance carriers to timely and accurately report the amount of commissions earned by us, and we calculate our commission revenue, prepare our financial reports, projections and budgets and direct our marketing and other operating efforts based on the reports we receive from health insurance carriers. There have been instances where we have determined that policy cancellation data reported to us by a health insurance carrier has not been completely accurate. Although we recognize commissions reported to us net of estimated cancellations, the extent to which

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health insurance carriers are inaccurate in their reporting of policy cancellations could cause us to change our cancellation estimates, which could adversely impact our revenues. We apply judgment and make estimates based on historical data and current trends to independently determine whether or not carriers are accurately reporting commissions due to us. To the extent that health insurance carriers understate or fail to accurately report the amount of commissions due to us in a timely manner or at all, we will not recognize revenue to which we are entitled, which would harm our business, operating results and financial condition.

We also depend on health insurance carriers and others for data related to our membership. For instance, with respect to health insurance plans other than small business health insurance, health insurance carriers do not directly report member cancellations to us, resulting in the need for us to determine cancellations using payment data that carriers provide. We infer cancellations from this payment data by analyzing whether payments from members have ceased for a period of time, and we may not learn of a cancellation for several months, given that some of our members pay on a schedule less frequently than monthly (e.g., quarterly). With respect to our small business membership, many groups notify the carrier directly with respect to increases or decreases in group size and policy cancellations. Our insurance carrier partners often do not communicate this information to us, and it often takes a significant amount of time for us to learn about small business group cancellations and changes in our membership within the group itself. We often are not made aware of policy cancellations until the time of the group’s annual renewal.

A substantial number of our existing members may become eligible for subsidies in connection with their purchase of health insurance. We may experience difficulty in satisfying the conditions required to offer plans to individuals and families who are entitled to subsidies under health care reform, and even if we are able to satisfy them, we depend upon states to permit us to offer these plans and upon health insurance companies to allow us to sell them and to pay us commissions in connection with their sale. In the event we are not successful in gaining the ability to sell individual and family health insurance products to health care reform subsidy-eligible individuals, or if health insurance carriers pay us no commissions or reduced commissions in connection with the sale of these plans, we could lose a substantial number of existing and potential members and the related commission revenue we receive as a result of the sale of individual and family and small business health insurance products to them, which would materially harm our business, operating results and financial condition. In addition, even if we are able to sell qualified health plans to subsidy eligible individuals, and particularly if states or health insurance carriers adopt open enrollment periods outside of state health insurance exchanges, it may be difficult for us to handle as a business the large amount of health insurance transactions occurring in a limited window of time. In the aggregate, a shift to open enrollment periods of limited duration in the individual and family and small business health insurance markets may result in a reduction in our membership and revenue; increase in our expenses, particularly during certain periods of the year, make it difficult for health insurance carriers to accurately report commission information to us in a timely manner, which would also make it difficult for us to accurately estimate our membership; and otherwise may harm our business, operating results and financial condition, particularly given that the open enrollment for qualified health plans and perhaps other health plans overlaps with the annual enrollment period for Medicare plans.

After we have estimated membership for a period, we may receive information from health insurance carriers that would have impacted the estimate if we had received the information prior to the date of estimation. We may receive commission payments or other information that indicates that a member who was not included in our estimates for a

prior period was in fact an active member at that time, or that a member who was included in our estimates was in fact not an active member of ours. We also reconcile information health insurance carriers provide to us and may determine that we were not historically paid commissions owed to us, which would cause us to have underestimated our membership. As a result of open enrollment periods, we may not receive information from our carriers on as timely a basis as in the past due to significant spikes in volume, which could impair the accuracy of our estimates of the number of members we have for a period of time. Additionally, health insurance carriers may require us to return commission payments paid in a prior period due to policy cancellations for members we previously estimated as being active. For these and other reasons, including if current trends in membership cancellation are inconsistent with past cancellation trends that we use to estimate our membership or if carriers subsequently report changes to the commission payments that they previously reported to us, our actual membership could be different from our estimates, perhaps materially. Total revenue per estimated member for the period would also change if our estimated membership changed. Our estimate regarding the average amount of time our members maintain their health insurance plans also could be inaccurate as it depends on the accuracy of our membership estimates.

Our operating results fluctuate depending upon health insurance carrier payment practices and the timing of our receipt of commission reports from health insurance carriers.

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The timing of our revenue depends upon the timing of our receipt of commission reports and associated payments from health insurance carriers. There have been instances where the report of commissions and payment have been delayed, such as during holiday periods. Any delay could materially impact our financial results for a given quarter as we would not be able to recognize the related commission revenue in that quarter. In addition, much of our commission override revenue is not reported and paid to us in accordance with a scheduled pattern, and some is only reported and paid to us once per year. The timing of our revenue recognition could result in a large amount of commission revenue from a carrier being recorded in a given quarter that is not indicative of the amount of revenue we may receive from that carrier in subsequent quarters, causing fluctuations in our operating results. We also could report revenue below the expectations of our investors or securities analysts in any particular period if a material report or payment from a health insurance carrier were delayed or not received within the time frame required for revenue recognition.

The implementation of open enrollment periods under health care reform for the purchase of individual health insurance may present challenges to our ability to enroll a significant number of individuals into health insurance over a limited period of time. Significant increases in enrollment activity over a limited amount of time may also make it difficult for health insurance carriers to timely and accurately report commission information to us. To the extent health insurance carriers have difficulty in reporting timely and accurate commission information to us, we may be unable to recognize revenue in accordance with our revenue recognition policies, which could cause us to defer a substantial amount of revenue until such time our health insurance carriers are able to resume reporting timely and accurate commission information to us.

We may be unsuccessful in competing effectively against current and future competitors.

The market for selling health insurance plans is highly competitive. We compete with entities and individuals that offer and sell health insurance plans utilizing traditional distribution channels as well as the Internet. Our competitors include local insurance agents across the United States who sell health insurance plans in their communities. There are a number of agents that operate websites and provide an online shopping experience for consumers interested in purchasing health insurance. To remain competitive against our current and future competitors, we will need to continue to invest and improve the online shopping experience and functionalities of our website and other platforms that our current and future customers may access to purchase health insurance products from us. If we cannot predict, develop and deliver the right shopping experience and functionality in a timely and cost-effective manner, we may not be able to compete successfully against our current or future competitors and our business, operating results and financial condition may be adversely affected.

Some local agents use “lead aggregator” services that use the Internet to find consumers interested in purchasing health insurance and are compensated for referring those consumers to the traditional agent. In addition to health insurance brokers and agents, many health insurance carriers directly market and sell their plans to consumers through call centers and their own websites. Although we offer health insurance plans for many of these carriers, they also compete with us by offering their plans directly to consumers. We will also compete with state and federal health insurance exchanges implemented as a result of health care reform. Health care reform also will result in health insurance plan cost and benefit data being more readily accessible, which could facilitate additional competition. In connection with our marketing of Medicare plans, we also compete with the original Medicare program. In addition, CMS offers plan information, comparison tools, call centers and online enrollment for Medicare Advantage and Medicare Part D

prescription drug plans.

In licensing our health insurance purchasing platform, we compete with companies providing technology that automates premium quoting, research and analysis of health insurance plans, member enrollment and other tools that support online sales efforts by health insurance carriers and their agents and brokers.

We may not be able to compete successfully against our current or future competitors. Some of our current and potential competitors have longer operating histories, larger customer bases, greater brand recognition and significantly greater financial, technical, marketing and other resources than we do. As compared to us, our current and future competitors may be able to:

- undertake more extensive marketing campaigns for their brands and services;
- devote more resources to website and systems development;
- negotiate more favorable commission rates and commission override payments; and
- make more attractive offers to potential employees, marketing partners and third-party service providers.

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In addition, CMS has the ability to regulate our marketing and sale of Medicare Advantage and Medicare Part D prescription drug plans and also could impact the commissions we receive in connection with the sale of these plans.

Competitive pressures may result in our experiencing increased marketing costs, decreased traffic to our website and loss of market share, or may otherwise harm our business, operating results and financial condition.

There are many risks associated with our operations in China.

A portion of our operations is conducted in China. Among other things, we use employees in China to maintain and update our ecommerce platform. This and other information is delivered to us through secured communications over the Internet. Our business would be harmed if this connection temporarily failed and we were prevented from promptly updating our software or implementing other changes to our database and systems. Our operations in China also expose us to different and unfamiliar laws, rules and regulations, including different intellectual property laws, which are not as protective of our intellectual property as the laws in the United States, and different labor and tax laws. United States and Chinese trade laws may impose restrictions on the importation of programming or technology to or from the United States. Additionally, we have recently experienced greater competition for qualified personnel in China, which has raised market salaries and increased our compensation costs related to employees in that location. If competition for personnel increases further, our compensation expenses could rise considerably or, if we determine to not increase compensation levels, our ability to attract and retain qualified personnel in China may be impaired, which could harm our business, operating results and financial condition. These risks could cause us to incur increased expenses and could harm our ability to effectively and successfully manage our operations in China, which in turn could cause our business, operating results and financial condition to suffer.

Our subsidiary in China has a subsidiary business insurance agency license in the Fujian province in China pursuant to which we may sell health, accident and life insurance in the Fujian province. Our license is up for renewal at the end of 2014. We have relationships with insurance companies to host on our technology platform certain of those companies' products that are offered throughout China. Additionally, we have entered, and may in the future continue to enter, into relationships with marketing partners to refer additional consumers to our website. We have limited experience marketing or selling insurance in China or in adapting our business and ecommerce platform to Chinese markets and cultures, legal and regulatory regimes or business customs. For instance, the laws and regulations applicable to our marketing and selling insurance online and assisting others in those efforts in China are unclear, and our operations may be in violation of them. In addition, insurance laws and regulations in China are in a state of development, and the laws and regulations may change to prohibit or restrict our marketing insurance online. The consequences of violating insurance and other applicable laws and regulations in China are unclear, but they could result in the termination of our license and our ability to host insurance products on our technology platform, payment of fines and damages and could harm our business as a whole. For various reasons, we may not expand in China, and even if we do, there can be no assurance that our ecommerce platform in China would ever generate a significant amount of revenue or otherwise be successful. Our success in establishing an insurance-related business in China also

depends on many of the factors that influence the success of our business in the United States, including, but not limited to, our receiving regulatory approvals (including the renewal of our license), acceptance of the Internet and our ecommerce platform as a marketplace for the purchase of insurance, our success in marketing our ecommerce platform and in retaining members who purchase insurance through that platform, our ability to enter into and maintain relationships with insurance carriers, commission rates, the affordability of the insurance products offered, insurance carrier business practices, the effectiveness with which we establish a brand identity, performance, reliability and availability of our ecommerce platform, competition, the regulatory environment and the manner in which health care delivery is financed and changes to such environment or manner, our ability to attract and retain qualified personnel and network security.

Our participation and success in the insurance market in China may be impacted by additional factors given that outside of Xiamen city, the insurance products offered on our website are offered directly by insurance carriers. As a result, our success in selling insurance outside of Xiamen city depends on many factors, including our dependence on insurance carriers for the products on our website, the insurance carriers' relationship with consumers, our relationship with the insurance carriers, the insurance carriers' ability to maintain licenses and regulatory approvals, and the number, quality and attractiveness of the insurance products offered by the insurance carriers through our platform. While there is no certainty that we would be able to expand our presence in the insurance industry in China, we may attempt to do so. If we decide to do so, we will need to receive additional government licenses and approvals or enter into additional relationships and we may face disadvantages in doing so as a result of our subsidiary in China being wholly foreign-owned.

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Our sponsorship and advertising business may not be successful.

We sell advertising space to health insurance carriers on our website through our sponsorship and advertising program. Our sponsorship and advertising program allows carriers to purchase advertising space in specific markets in a sponsorship area on our website. Health insurance carriers have and may continue to determine to eliminate or reduce spending on our sponsorship and advertising program as a result of various aspects of health care reform, including the medical loss ratio requirements that became effective in 2011. As a result, our business, operating results and financial condition could be harmed. To the extent that economic conditions, health care reform or other factors impact the amount health insurance carriers are willing to pay for advertising on our ecommerce platform, our sponsorship and advertising program will be adversely impacted. The success of our sponsorship and advertising program depends on a number of other factors, including the effectiveness of the sponsorship and advertising program as a cost-effective method for carriers to obtain additional members, consumer and health insurance carrier adoption of the Internet and our ecommerce platform as a medium for the purchase and sale of health insurance, our ability to attract consumers visiting our ecommerce platform and convert those consumers into members, the existence of a relationship between us and a diverse group of carriers that offer a number of health insurance plans in the markets in which we attempt to sell advertising, the cost, benefit and brand recognition of the health insurance plan that is the subject of the advertising, the impact the advertising has on the sale of the health insurance plan that is the subject of the advertising and the effectiveness of the carrier's other means of advertising. In addition, while our practice of selling advertising is described on our ecommerce platform, it could cause consumers to perceive us as not objective, which could harm our brand and result in a decline in our health insurance sales. It also could adversely impact our relationship with health insurance carriers that do not purchase our advertising. As a result, our business, operating results and financial condition could be harmed.

We also develop, host and maintain carrier dedicated Medicare plan websites through our advertising program. Our success in doing so is dependent upon the same factors that could impact our sponsorship program. In addition, since we maintain relationships with a limited number of health insurance carriers to sell their Medicare plans, our Medicare plan-related advertising revenue is concentrated in a small number of health insurance carriers and our ability to generate Medicare plan-related advertising revenue would be harmed by the termination or non-renewal of any of these relationships as well as by a reduction in the amount a health insurance carrier is willing to pay for these services. Moreover, in light of the regulations applicable to the marketing and sale of Medicare plans, and given that these regulations are often unclear, change frequently and are subject to changing interpretations, we may in the future not be permitted to sell Medicare plan-related advertising. If we are not successful in generating Medicare plan-related advertising revenue, our business operating results and financial condition could be harmed.

We may not be successful in licensing the use of our ecommerce technology to health insurance carriers and other third parties.

We license the use of our ecommerce technology to health insurance carriers and agents. Carriers use our platform to offer their own health insurance policies on their websites, and agents use it to power their quoting and online content.

If we do not grow our revenue from the license of our technology, or if the rate of growth declines, our business, operating results and financial condition may be harmed. The impact that health care reform may have on our technology licensing business is unclear. Health care reform could reduce health insurance carrier and agent demand for our technology licensing platform as a result of the medical loss ratio requirements that became effective in 2011 or for other reasons, and health insurance carriers who currently use the platform could determine to cease using it, reduce the number and type of plans offered on the platform or renegotiate the fees that they pay, any of which would reduce the revenue we receive from our technology licensing business.

The business of licensing the use of our technology to others could facilitate carrier, health insurance agent and other third party competition with us in the sale of health insurance over the Internet and is subject to a number of additional risks and uncertainties, including consumer and health insurance carrier adoption of our ecommerce platform as a medium for the purchase and sale of health insurance, our ability to establish relationships with new health insurance carriers, the reliability and performance of our ecommerce platform and the relative cost of developing competing technology. If we are not able to offer health insurance carriers and other third parties a reliable platform to cost-efficiently offer their plans over the Internet, our technology licensing business will be unsuccessful.

We may not be able to adequately protect our intellectual property, which could harm our business and operating results.

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We believe that our intellectual property is an essential asset of our business and that our technology infrastructure currently gives us a competitive advantage in the distribution of individual and family and small business health insurance. We rely on a combination of copyright, trademark and trade secret laws as well as confidentiality procedures and contractual provisions to establish and protect our intellectual property rights in the United States. Although we have applied for patents in the United States, they may not result in issued patents. We have not filed for protection of our intellectual property in any foreign jurisdiction other than China. We have Chinese-registered computer software copyrights for an internally-developed software system and a project management tool and have certain trademarks in China. We have not filed any patent applications in China. The efforts we have taken to protect our intellectual property may not be sufficient or effective, and our trademarks, copyrights and patents if issued, may be held invalid or unenforceable. Moreover, the law relating to intellectual property is not as developed in China, and our intellectual property rights may not be as respected in China as they are in the United States. Any United States or other patents issued to us may not be sufficiently broad to protect our proprietary technologies, and given the costs of obtaining patent protection, we may choose not to seek patent protection for certain of our proprietary technologies. We may not be effective in policing unauthorized use of our intellectual property, trade secrets and other confidential information, and even if we do detect violations, litigation may be necessary to enforce our intellectual property rights. Any enforcement efforts we undertake, including litigation, could be time-consuming and expensive, could divert our management's attention and may result in a court determining that our intellectual property or other rights are unenforceable. If we are not successful in cost-effectively protecting our intellectual property rights, trade secrets and confidential information, our business, operating results and financial condition could be harmed.

We may in the future be subject to intellectual property rights claims, which are extremely costly to defend, could require us to pay significant damages and could limit our ability to use certain technologies in the future.

There are a large number of patents, copyrights, trademarks and trade secrets applicable to the internet and technology industries and entities frequently enter into litigation based on allegations of infringement or other violations of intellectual property rights. We have received, and may in the future receive, notices that claim we have misappropriated, infringed or misused other parties' intellectual property rights, and, to the extent we gain greater visibility, we face a higher risk of being the subject of intellectual property infringement claims. There may be third-party intellectual property rights, including issued or pending patents that cover significant aspects of our technologies or business methods or that cover third-party technology that we use as a part of our websites. Any intellectual property claim against us, with or without merit, could be time consuming, expensive to settle or litigate and could divert our management's attention and other resources. These claims also could subject us to significant liability for damages and could result in our having to stop using technology found to be in violation of a third party's rights. We might be required to seek a license for third-party intellectual property, which may not be available on reasonable terms or at all. Even if a license is available, we could be required to pay significant royalties, which would increase our operating expenses. We may also be required to develop alternative non-infringing technology, which could require significant effort and expense. If we cannot license or develop technology for any infringing aspect of our business, we would be forced to limit our services and may be unable to compete effectively. Any of these results would harm our business, operating results and financial condition.

Any legal liability, regulatory penalties, or negative publicity for the information on our website or that we otherwise distribute or provide could harm our business and operating results.

We provide information on our website, through our customer care centers and in other ways regarding health insurance in general and the health insurance plans we market and sell, including information relating to insurance premiums, coverage, benefits, provider networks, exclusions, limitations, availability, plan comparisons and insurance company ratings. A significant amount of both automated and manual effort is required to maintain the considerable amount of insurance plan information on our website. Separately, from time to time, we use the information provided on our website and otherwise collected by us to publish reports designed to educate consumers, facilitate public debate, and facilitate reform at the state and federal level relating to the accessibility and affordability of health insurance. We also regularly provide health insurance plan information in our customer care centers. If the information we provide on our website, through our customer care centers or otherwise is not accurate or is construed as misleading, or if we do not properly assist individuals and businesses in purchasing health insurance, members, health insurance carriers and others could attempt to hold us liable for damages, our relationships with health insurance carriers could be terminated and regulators could attempt to subject us to penalties, revoke our licenses to transact health insurance business in a particular jurisdiction, and/or compromise the status of our licenses to transact health insurance business in other jurisdictions, which could result in our loss of our commission revenue. In the ordinary course of operating our business, we have received complaints that the information we provided was not accurate or was misleading. Although in the past we have resolved these complaints

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without significant financial cost, we cannot guarantee that we will be able to do so in the future. In addition, these types of claims could be time-consuming and expensive to defend, could divert our management's attention and other resources, and could cause a loss of confidence in our services. As a result, whether or not we are able to successfully resolve these claims, they could harm our business, operating results and financial condition.

In the ordinary course of our business, we have received and may continue to receive inquiries from state regulators relating to various matters. We have become, and may in the future become, involved in litigation in the ordinary course of our business. If we are found to have violated laws or regulations, we could lose our relationship with health insurance carriers and be subject to various fines and penalties, including revocation of our licenses to sell insurance, and our business, operating results and financial condition would be materially harmed. We would also be harmed to the extent that related publicity damages our reputation as a trusted source of information relating to health insurance and its affordability. It could also be costly to defend ourselves regardless of the outcome.

Changes in our management and key employees could affect our financial results.

Our success is dependent upon the performance of our senior management and key personnel. Our management and employees can terminate their employment at any time. Many of our senior management and key employees have sold shares of our common stock in the open market, and some have sold a significant portion of their vested holdings. These employees may be more likely to leave us given that they have liquidated some or a substantial percentage of their holdings. The loss of the services of any of our executive officers or key employees could harm our business. For example, we appoint a single writing agent with each insurance carrier. If we lose the service of our appointed writing agent, the duties of writing agent will need to be transitioned to other company personnel. Due to our national reach and the large number of carrier partners whose policies are purchased by our members, this transition may be difficult and requires a significant period of time to complete. If the transition is not successful or takes too long to complete, our agency relationship with particular insurance carriers may be terminated, our commission payments could be discontinued or delayed and, as a result, our business, operating results and financial condition would be harmed. Our success is also dependent upon our ability to attract additional personnel for all areas of our organization. We may not be successful in attracting and retaining personnel on a timely basis, on competitive terms or at all. If we are unable to attract and retain the necessary personnel, our business would be harmed.

In March 2012 we hired a new president and chief operating officer, and in April 2012 the employment of our executive vice president of business and corporate development and the employment of our chief technology officer terminated. We are likely to experience change in our operations as a result. If we are not effective in managing this transition in our leadership and changes in our operations, our business could be adversely impacted and our operating results and financial condition could be harmed.

If we fail to manage the expansion of our business, our business and operating results would be harmed.

We have expanded our operations significantly and have recently entered into the business of selling Medicare plans. Our entering into this new area of business places increasing and significant demands on our management, our operational and financial systems and infrastructure and our other resources. If we do not effectively manage this expansion, the quality of our services could suffer, which could harm our business, operating results and financial condition. In order to successfully expand our business, we need to hire, integrate and retain highly skilled and motivated employees. We also need to continue to improve our existing systems for operational and financial management, including our reporting systems, procedures and controls. These improvements could require significant capital expenditures and place increasing demands on our management. We may not be successful in managing or expanding our operations or in maintaining adequate financial and operating systems and controls. If we do not successfully implement improvements in these areas, our business, operating results and financial condition will be harmed.

Seasonality may cause fluctuations in our financial results.

The number of individual and family health insurance applications submitted through our ecommerce platform has generally increased in our first quarter compared to our fourth quarter and in our third quarter compared to our second quarter. Conversely, we have generally experienced a decline or flattening of individual and family submitted applications in our second quarter compared to our first quarter and in our fourth quarter compared to our third quarter. The majority of Medicare plans are sold in our fourth quarter during the Medicare annual enrollment period, when Medicare-eligible individuals are permitted to change their Medicare Advantage and Medicare Part D prescription drug coverage for the

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following year. As a result, we generate a significant amount of Medicare plan-related revenue in the fourth quarter of the year. Additionally, we recognize a majority of our renewal Medicare Advantage and Medicare Part D prescription drug plan commission revenue in the first quarter of each year as the majority of Medicare policies sold during the annual enrollment period typically renew on January 1 of each year.

Since a significant portion of our marketing and advertising expenses are driven by the number of health insurance applications submitted on our ecommerce platform, those expenses are influenced by these seasonal patterns. As a result, marketing and advertising expenses related to individual and family health insurance plans are highest in our first and third quarters, while marketing and advertising expenses related to Medicare plans are highest in our third and fourth quarters. Additionally, in preparation for the Medicare annual enrollment period, we begin ramping up our temporary customer care center staff during our second and third quarters and employ our temporary customer care center staff until the end of the Medicare annual enrollment period in December. Accordingly, our customer care center staffing costs are significantly higher in our third and fourth quarters compared to our first and second quarters.

Based on these seasonal trends, our revenue is highest in the fourth quarter of the year and our profitability is relatively higher in the first and fourth quarters and substantially lower in the third quarter of the year.

It is unclear what the impact of open enrollment periods for the purchase of major medical health insurance plans will have on our marketing and advertising expenses, although we expect the seasonal patterns for individual and family plan submitted applications, and marketing and advertising expenses, will be impacted. The next open enrollment period is scheduled to begin in October 2013 and run through March 2014, and then is scheduled to occur within the fourth quarter each calendar year starting in October 2014. We expect our total marketing expenses will increase during the open enrollment period as an increased number of consumers switch health insurance policies.

Under the federal Patient Protection and Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act, health insurance plans are required to be purchased by individuals, families and small businesses through government-run health insurance exchanges during an initial open enrollment period scheduled to begin in October 2013 and run through March 2014 in order for the individual, family or small business to receive subsidies from the government. Subsidy-eligible individuals, families and small businesses can thereafter change their qualified health plan only during annual enrollment period scheduled to occur from October 15 through December 7 of each year thereafter, subject to states extending the period and exceptions for special enrollment periods for certain qualifying events. Moreover, some health insurance carriers and states have adopted, and others may adopt, open enrollment periods for the sale of health insurance outside of these exchanges. To the extent states or health insurance carriers allow us to market subsidy-eligible health plans and to the extent states or health insurance carriers adopt open enrollment periods for the sale of individual and family and small business health insurance in general, we will experience additional seasonality in both our sales volumes and expenses as a result of the enrollment period, which could have an adverse effect on our business, operating results and financial condition.

Acquisitions could disrupt our business and harm our financial condition and operating results.

We may decide to acquire businesses, products and technologies. Our ability as an organization to successfully make and integrate acquisitions is unproven. Acquisitions could require significant capital infusions and could involve many risks, including the following:

- an acquisition may negatively impact our results of operations because it will require us to incur transaction expenses, and after the transaction, may require us to incur charges and substantial debt or liabilities, may require the amortization, write down or impairment of amounts related to deferred compensation, goodwill and other intangible assets, or may cause adverse tax consequences, substantial depreciation or deferred compensation charges;

- an acquisition undertaken for strategic business purposes may negatively impact our results of operations;

- we may encounter difficulties in assimilating and integrating the business, technologies, products, personnel or operations of companies that we acquire, particularly if key personnel of the acquired company decide not to work for us;

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- an acquisition may disrupt our ongoing business, divert resources, increase our expenses and distract our management;

- we may be required to implement or improve internal controls, procedures and policies appropriate for a public company at a business that prior to the acquisition lacked these controls, procedures and policies;

- the acquired businesses, products or technologies may not generate sufficient revenue to offset acquisition costs or to maintain our financial results;

- we may have to issue equity securities to complete an acquisition, which would dilute our stockholders' ownership and could adversely affect the market price of our common stock; and

- acquisitions may involve the entry into geographic or business markets in which we have little or no prior experience.

We cannot assure you that we will be able to identify or consummate any future acquisition on favorable terms, or at all. If we do pursue an acquisition, it is possible that we may not realize the anticipated benefits from the acquisition or that the financial markets or investors will negatively view the acquisition. Even if we successfully complete an acquisition, it could harm our business, operating results and financial condition.

If we fail to maintain proper and effective internal controls, our ability to produce accurate financial statements could be impaired, which could adversely affect our operating results, our ability to operate our business and our stock price.

We have a complex business organization, and we recently expanded our business operations into the sale of Medicare plans. Ensuring that we have adequate internal financial and accounting controls and procedures in place to help ensure that we can produce accurate financial statements on a timely basis is a costly and time-consuming effort that needs to be re-evaluated frequently and is complicated by the expansion of our business operations. Our management, including our chief executive officer and chief financial officer, does not expect that our internal control over financial reporting will prevent all errors or all fraud. A control system, no matter how well designed and operated, can provide only reasonable, not absolute, assurance that the control system's objectives will be met. Further, the design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Controls can be circumvented by the individual acts of some persons, by collusion of two or more people, or by management override of the controls. Over time, controls may become inadequate because changes in conditions or deterioration in the degree of compliance with policies or procedures may occur. Because of the inherent limitations in a cost-effective control system, misstatements due to error or fraud may occur and not be detected.

As a result, we cannot assure that significant deficiencies or material weaknesses in our internal control over financial reporting will not be identified in the future. Any failure to maintain or implement required new or improved controls, or any difficulties we encounter in their implementation, could result in significant deficiencies or material weaknesses, cause us to fail to timely meet our periodic reporting obligations, or result in material misstatements in our financial statements. Any such failure could also adversely affect the results of periodic management evaluations and annual auditor attestation reports regarding disclosure controls and the effectiveness of our internal control over financial reporting required under Section 404 of the Sarbanes-Oxley Act of 2002 and the rules promulgated thereunder. The existence of a material weakness could result in errors in our financial statements that could result in a restatement of financial statements, cause us to fail to timely meet our reporting obligations and cause investors to lose confidence in our reported financial information, leading to a decline in our stock price and potential lawsuits against us.

Changes in our provision for income taxes or adverse outcomes resulting from examination of our income or other tax returns could adversely affect our results.

Our provision for income taxes is subject to volatility and could be adversely affected by earnings differing materially from our projections, changes in the valuation of our deferred tax assets and liabilities, expiration of or lapses in the research and development tax credit laws, tax effects of share-based compensation or by changes in tax laws, regulations, accounting principles, including accounting for uncertain tax positions, or interpretations thereof. For instance, in October 2010, the state of California approved budget legislation which substantially limited the utilization of net operating losses. The new law did not affect the amount of net operating losses and tax credits that we expect to ultimately use to offset future

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California taxes, but limited the amount we could utilize in 2010 and 2011, resulting in our paying higher cash taxes. To the extent that our provision for income taxes is subject to volatility or adverse outcomes as a result of tax examinations, our operating results could be harmed.

Significant judgment is required to determine the recognition and measurement attribute prescribed in U.S. generally accepted accounting principles ("U.S. GAAP") relating to accounting for income taxes. In addition, U.S. GAAP applies to all income tax positions, including the potential recovery of previously paid taxes, which if settled unfavorably could adversely impact our provision for income taxes or additional paid-in capital. In addition, we are subject to examinations of our income tax returns by the Internal Revenue Service and other tax authorities. We assess the likelihood of adverse outcomes resulting from these examinations to determine the adequacy of our provision for income taxes. There may be exposure that the outcomes from these examinations will have an adverse effect on our operating results and financial condition.

Risks Related to State Insurance Regulation

Regulation of the sale of health insurance is subject to change, and future regulations could harm our business and operating results.

The laws and regulations governing the offer, sale and purchase of health insurance are subject to change, and future changes may be adverse to our business. For example, a long standing provision in each state's law that we believe is advantageous to our business is that once health insurance premiums are set by the carrier and approved by state regulators, they are fixed and not generally subject to negotiation or discounting by insurance companies or agents. Additionally, state regulations generally prohibit carriers, agents and brokers from providing financial incentives, such as rebates, to their members in connection with the sale of health insurance. As a result, we do not currently compete with carriers or other agents and brokers on the price of the health insurance plans offered on our website. If these regulations change, we could be forced to reduce prices or provide rebates or other incentives for the health insurance plans sold through our ecommerce platform, which would harm our business, operating results and financial condition.

States have, and will continue, to adopt new laws and regulations in response to health care reform legislation. It is difficult to predict how these new laws and regulations will impact our business, but in some cases such laws and regulations could amplify the adverse impacts of health care reform, or states may adopt new requirements that adversely impact our business, operating results and financial condition.

We are also subject to additional insurance regulatory risks, because we use the Internet as our distribution platform. In many cases, it is not clear how existing insurance laws and regulations apply to Internet-related health insurance advertisements and transactions. To the extent that new laws or regulations are adopted that conflict with the way we conduct our business, or to the extent that existing laws and regulations are interpreted adversely to us, our business, operating results and financial condition would be harmed.

If we fail to comply with the numerous state laws and regulations that are applicable to the sale of health insurance, our business and operating results could be harmed.

The sale of health insurance is heavily regulated by each state in the United States. For instance, in addition to the impact and changes in regulations resulting from health care reform, state regulators require us to maintain a valid license in each state in which we transact health insurance business and further require that we adhere to sales, documentation and administration practices specific to that state. In addition, each employee who transacts health insurance business on our behalf must maintain a valid license in one or more states. Because we do business in all 50 states and the District of Columbia, compliance with health insurance-related laws, rules and regulations is difficult and imposes significant costs on our business. Each jurisdiction’s insurance department typically has the power, among other things, to:

· grant and revoke licenses to transact insurance business;

· conduct inquiries into the insurance-related activities and conduct of agents and agencies;

· require and regulate disclosure in connection with the sale and solicitation of health insurance;

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- authorize how, by which personnel and under what circumstances insurance premiums can be quoted and published and an insurance policy sold;

- approve which entities can be paid commissions from carriers and the circumstances under which they may be paid;

- regulate the content of insurance-related advertisements, including web pages, and other marketing practices;

- approve policy forms, require specific benefits and benefit levels and regulate premium rates;

- impose fines and other penalties; and

- impose continuing education requirements.

Due to the complexity, periodic modification and differing interpretations of insurance laws and regulations, we may not have always been, and we may not always be, in compliance with them. New insurance laws, regulations and guidelines also may not be compatible with the sale of health insurance over the Internet or with various aspects of our platform or manner of marketing or selling health insurance plans. Failure to comply with insurance laws, regulations and guidelines or other laws and regulations applicable to our business could result in significant liability, additional department of insurance licensing requirements, the revocation of licenses in a particular jurisdiction and/or our inability to sell health insurance plans, which could significantly increase our operating expenses, result in the loss of our commission revenue and otherwise harm our business, operating results and financial condition. Moreover, an adverse regulatory action in one jurisdiction could result in penalties and adversely affect our license status or reputation in other jurisdictions due to the requirement that adverse regulatory actions in one jurisdiction be reported to other jurisdictions. Even if the allegations in any regulatory or other action against us are proven false, any surrounding negative publicity could harm consumer, marketing partner or health insurance carrier confidence in us, which could significantly damage our brand. Because some consumers, marketing partners and health insurance carriers may not be comfortable with the concept of purchasing health insurance using the Internet, any negative publicity may affect us more than it would others in the health insurance industry and would harm our business, operating results and financial condition. Changes in insurance laws, regulations and guidelines may also be incompatible with various aspects of our business and require that we make significant modifications to our existing technology or practices, which may be costly and time-consuming to implement and could also harm our business, operating results and financial condition.

In addition, we have received, and may in the future receive, inquiries from regulators regarding our marketing and business practices. We typically respond by explaining how we believe we are in compliance with relevant regulations or may modify our practices in connection with the inquiry. Any modification of our marketing or business practices in response to future regulatory inquiries could harm our business, operating results or financial condition.

Risks Related to the Internet and Electronic Commerce

Our business is subject to security risks and, if we are unable to safeguard the security and privacy of confidential data, including personal health information, our business will be harmed.

Our services involve the collection and storage of confidential information of consumers and the transmission of this information to their chosen health insurance carriers. For example, we collect names, addresses, Social Security and credit card numbers, and information regarding the medical history of consumers in connection with their applications for health insurance. As a result, we are subject to various federal, state and international laws and regulations regarding the collection, maintenance, protection, use, transmission, disclosure and disposal of sensitive personal information. We cannot guarantee that our facilities and systems, and those of our third party service providers, will be free of security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Compliance with privacy and security laws, requirements and regulations may result in cost increases due to new constraints on our business, the development of new processes, the effects of potential non-compliance by third party service providers, and enforcement actions. We may be required to expend significant capital and other resources to protect against security breaches or to alleviate problems caused by security breaches. Despite our implementation of security measures, techniques used to obtain unauthorized access or to sabotage systems change frequently. As a result, we may be unable to anticipate these techniques or to implement adequate preventative measures. Additionally, although our third party service providers are required to implement appropriate security measures, we have limited control over their actions and practices.

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Any compromise or perceived compromise of our security could damage our reputation and the termination of our relationship with our members, marketing partners and health insurance carriers, could reduce demand for our services and could subject us to significant liability and expense as well as regulatory action and private privacy-related lawsuits, which would harm our business, operating results and financial condition. In addition, in the event that data security laws are implemented, or our health insurance carrier or other partners determine to impose new requirements on us relating to data security, we may not be able to timely comply with such requirements or such requirements may not be compatible with our current processes. Changing our processes could be time consuming and expensive, and failure to timely implement required changes could result in our inability to sell health insurance plans in a particular jurisdiction or for a particular health insurance carrier or subject us to liability for non-compliance, any of which would damage our business, operating results and financial condition.

Government regulation of the Internet could adversely affect our business.

The laws governing general commerce on the Internet remain unsettled and it may take years to fully determine whether and how existing laws such as those governing intellectual property, privacy and taxation apply to the Internet. In addition, the growth and development of the market for electronic commerce may prompt calls for more stringent consumer protection laws that may impose additional burdens on companies conducting business over the Internet. Any new laws or regulations or new interpretations of existing laws or regulations relating to the Internet could harm our business and we could be forced to incur substantial costs in order to comply with them, which would harm our business, operating results and financial condition.

Our business could be harmed if we are unable to correspond with our consumers or market the availability of our ecommerce platform by email.

We use email to market our services to potential members and as the primary means of communicating with our existing members. The laws and regulations governing the use of email for marketing purposes continue to evolve and the growth and development of the market for commerce over the Internet may lead to the adoption of additional legislation. If new laws or regulations are adopted, or existing laws and regulations are interpreted, to impose additional restrictions on our ability to send email to our members or potential members, we may not be able to communicate with them in a cost-effective manner. In addition to legal restrictions on the use of email, Internet service providers, e-mail service providers and others attempt to block the transmission of unsolicited email, commonly known as “spam.” Many Internet and e-mail service providers have relationships with organizations whose purpose it is to detect and notify the Internet and e-mail service providers of entities that the organization believes is sending unsolicited e-mail. If an Internet or e-mail service provider identifies email from us as “spam” as a result of reports from these organizations or otherwise, we can be placed on a restricted list that will block our email to members or potential members. If we are unable to communicate by email with our members and potential members as a result of legislation, blockage or otherwise, our business, operating results and financial condition would be

harmed.

Consumers depend upon third-party service providers to access our website, and our business and operating results could be harmed as a result of technical difficulties experienced by these service providers.

Consumers using our website depend upon Internet, online and other service providers for access to our website. Many of these service providers have experienced significant outages, delays and other difficulties in the past and could experience them in the future. Any significant interruption in access to our website or increase in our website's response time as a result of these difficulties could damage our relationship with insurance carriers, marketing partners and existing and potential members and could harm our business, operating results and financial condition.

Risks Related to the Ownership of Our Common Stock

The trading price of our common stock may be subject to significant fluctuations and volatility, and our stockholders may be unable to resell their shares at a profit.

The stock markets, in general, and the markets for high technology stocks in particular, have historically experienced high levels of volatility. The market for technology stocks has been extremely volatile and frequently reaches levels that bear no relationship to the past or present operating performance of those companies. These broad market fluctuations may adversely affect the trading price of our common stock. In addition, the trading price of our common stock has been subject

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to significant fluctuations and may continue to fluctuate or decline, particularly as a result of developments relating to health care reform legislation. Factors that could cause fluctuations in the trading price of our common stock include, but are not limited to, the following:

- price and volume fluctuations in the overall stock market from time to time;
- significant volatility in the market price and trading volume of technology companies in general, and companies in our industry;
- actual or anticipated changes in our results of operations or fluctuations in our operating results;
- actual or anticipated changes in the expectations of investors or securities analysts, including changes in financial estimates or investment recommendations by securities analysts who follow our business and changes in perceptions relating to the economy;
- speculation in the press or investment community;
- technological advances or introduction of new products by us or our competitors;
- actual or anticipated developments in our competitors' businesses or the competitive landscape generally;
- litigation involving us, our industry or both;
- actual or anticipated regulatory developments in the United States or foreign countries, including health care reform legislation in the United States;
- major catastrophic events;
- announcements or developments relating to the economy;
- our sale of common stock or other securities in the future;
- the trading volume of our common stock, as well as sales of large blocks of our stock; or

· departures of key personnel.

These factors, as well as general economic and political conditions and the announcement of proposed and completed acquisitions or other significant transactions, or any difficulties associated with such transactions, by us or our strategic partners, customers or our current competitors, may materially adversely affect the market price of our common stock in the future. In the past, following periods of volatility in the market price of a company's securities, securities class action litigation has often been instituted against that company. Such litigation could result in substantial cost and a diversion of management's attention and resources. In addition, volatility, lack of positive performance in our stock price or changes to our overall compensation program, including our equity incentive program, may adversely affect our ability to retain key employees.

A limited number of stockholders have the ability to influence the outcome of director elections and other matters requiring stockholder approval.

A small number of greater than 5% stockholders and their affiliated entities beneficially owned more than 50% percent of our outstanding common stock as of June 30, 2013. These stockholders, if they act together, could exert substantial influence over matters requiring approval by our stockholders, including the election of directors, the amendment of our certificate of incorporation and bylaws and the approval of mergers or other business combination transactions. This concentration of ownership may discourage, delay or prevent a change in control of our company, which could deprive our stockholders of an opportunity to receive a premium for their stock as part of a sale of our company and might reduce our stock price. These actions may be taken even if they are opposed by other stockholders.

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Certain provisions in our charter documents and Delaware law could discourage takeover attempts and lead to management entrenchment.

Our certificate of incorporation and bylaws contain provisions that could have the effect of delaying or preventing changes in control or changes in our management without the consent of our board of directors. These provisions include:

- a classified board of directors with three-year staggered terms, which may delay the ability of stockholders to change the membership of a majority of our board of directors;

- cumulative voting in the election of directors is prohibited, which limits the ability of minority stockholders to elect director candidates;

- the exclusive right of our board of directors to elect a director to fill a vacancy created by the expansion of the board of directors or the resignation, death or removal of a director, which prevents stockholders from being able to fill vacancies on our board of directors;

- the ability of our board of directors to determine to issue shares of preferred stock and to determine the price and other terms of those shares, including preferences and voting rights, without stockholder approval, which could be used to significantly dilute the ownership of a hostile acquiror;

- a prohibition on stockholder action by written consent, which forces stockholder action to be taken at an annual or special meeting of our stockholders;

- the requirement that a special meeting of stockholders may be called only by the chairman of the board of directors, the chief executive officer or the board of directors, which may delay the ability of our stockholders to force consideration of a proposal or to take action, including the removal of directors; and

- advance notice procedures that stockholders must comply with in order to nominate candidates to our board of directors or to propose matters to be acted upon at a stockholders' meeting, which may discourage or deter a potential acquiror from conducting a solicitation of proxies to elect the acquiror's own slate of directors or otherwise attempting to obtain control of us.

We are also subject to certain anti-takeover provisions under Delaware law. Under Delaware law, a corporation may, in general, not engage in a business combination with any holder of 15% or more of its capital stock unless the holder has held the stock for three years or, among other things, the board of directors has approved the transaction.

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We are also subject to certain anti-takeover provisions under Delaware law. Under Delaware law, a corporation may, in general, not engage in a business combination with any holder of 15% or more of its capital stock unless the holder has held the stock for three years or, among other things, the board of directors has approved the transaction. 2

ITEM 2. UNREGISTERED SALES OF EQUITY SECURITIES AND USE OF PROCEEDS

Issuer Purchases of Equity Securities

On September 10, 2012, we announced that our board of directors approved a stock repurchase program authorizing us to purchase up to $30 million of our common stock. On March 6, 2013, we announced that our board of directors increased the previously approved repurchase amount of $30 million by an additional $30 million such that the total amount that we may repurchase under the repurchase program would be $60 million. Purchases under the repurchase program were made in the open market and complied with Rule 10b-18 under the Securities Exchange Act of 1934, as amended. The cost of the repurchased shares was funded from available working capital. We completed repurchasing common stock under this program in June 2013 having repurchased 2,957,179 shares for $60.0 million at an average price of $20.29 per share.

For accounting purposes, common stock repurchased under our stock repurchase programs is recorded based upon the settlement date of the applicable trade. Such repurchased shares are held in treasury and are presented using the cost method. The table below is a summary of stock repurchases for the three months ended June 30, 2013.

Period	Total Number of Shares Repurchased	Average Price Paid Per Share	Total Number of Shares Purchased as Part of Publicly Announced Program	Approximate Dollar Value of Shares that May Yet be Purchased under the Program (in thousands)
Beginning repurchase authority				$ 30,000 (1)
April 1—April 30, 2013	-	-	-	$ 30,000

May 1—May 31, 2013	1,064,888	$ 23.23	1,064,888	$ 5,258
June 1—June 30, 2013	212,608	$ 24.73	212,608	$ -
Total as of June 30, 2013	1,277,496	$ 23.48	1,277,496	$ -

(1) The amount reflects the $30 million increase of the repurchase authorization approved by our board of directors in March 2013.

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ITEM 6. EXHIBITS

(a) Exhibits

Except as so indicated in Exhibits 32.1 and 32.2, the following exhibits are filed as part of, or incorporated by reference into, this quarterly report.

Exhibit Number	Description of Exhibit	Incorporation by Reference Herein	
		Form	Date
10.19.1	First Amendment to the Lease Agreement, effective as of May 28, 2013, between eHealth, Inc. and 340 Middlefield, LLC.	Current Report on Form 8-K (File No. 001-33071)	May 29, 2013
10.16.7	Supplemental Agreement, effective as of April 1, 2013, between eHealth China (Xiamen) Technology Co., Ltd. and Xiamen Software Industry Investment & Development Co., Ltd.	Current Report on Form 8-K (File No. 001-33071)	May 15, 2013
31.1	†Certification of Gary L. Lauer, Chief Executive Officer of eHealth, Inc., pursuant to Exchange Act Rule 13a-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.		
31.2	†Certification of Stuart M. Huizinga, Chief Financial Officer of eHealth, Inc., pursuant to Exchange Act Rule 13a-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.		
32.1	‡Certification of Gary L. Lauer, Chief Executive Officer of eHealth, Inc., pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.		
32.2	‡Certification of Stuart M. Huizinga, Chief Financial Officer of eHealth, Inc., pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.		
101.INS	XBRL Instance Document		
101.SCH	XBRL Taxonomy Extension Schema Document		
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document		
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document		
101.LAB	XBRL Taxonomy Extension Label Linkbase Document		
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document		

† Filed herewith.
‡ Furnished herewith.
* Indicates a management contract or compensatory plan or arrangement.

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SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized on the 7th day of August 2013.

/ s / Gary L. Lauer

Gary L. Lauer

Chief Executive Officer

(Duly Authorized Officer on Behalf of the Registrant)

/ s / Stuart M. Huizinga

Stuart M. Huizinga

Chief Financial Officer

(Principal Financial Officer)

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